Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 Month 2:39 PM Physician/ June William T. Davis Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City Health & Rehab Center Ellicott City 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Sept. 24, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Country) MD **Funeral** Hours 216-28-3561 1931 1 X M 2 □ F 80 Director Usual Residence of Decede show 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director 1 Yes 2 X No 28a-f Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number ò Funeral 23a 4596 Roundhill Road USA 21043 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status ral", or iten Examiner r Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. 1 Never Married 2 X Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White 3 Widowed 4 Divorced "natural", ar or Dates. Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N NSA Systems Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Madeline Keen William T. Davis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4596 Roundhill Road Ellicott City, MD 21043 Mrs. Betty Davis (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) 6/9/2012 Marriottsville, MD Mt. View Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final andio Vas Cellas Physician/ disease or condition resulting in death) Medical Disease **Examiner** VKInsm. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last /sician Physician/Medical Division of Vital Records, P.O. Box 68760 the P) IF FEMALE ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year for 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deat Funeral Director: Suicide Could not be 28f. Location (Street and Number or Rural Route Number, . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in multiplication in multiplication in multiplication. Medical 29a. Certifier within 24 hor **To the Fune** completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, if my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar Back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapathi

201-109

D30641

River Neck Road

May land 2/22/

Balhmore

			Type or Pri	nt in Black I							jible.		
	_	For State Registrar				e of Deat			Reg. No	0.0	112	1800	2
ysicia		1. Decedent's Name (First, Middle, Late Marian Dal	,					2. Date of De June	eath 06	ay 2	0 1 2	3. Time of Death 9 ; 18 A	Λ
Medic kamin		4a. Facility Name (if not institution, give	d Club Di	rive		4b. City, Town, or Location of Death Lutherville 4c. County of Death Baltimore							
neral ector		5. Social Security Number 6. S 220 – 46 – 2301 1  Usual Residence of Decedent	Sex 7. Ag	7. Age (In yrs. last birthday) 81 Yrs.   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. E   Months   Days   Hours   Min.   Min.   Months   Min.   Months   Min.   Min						9. Birthp Count Bal	lace (State or Foreig ry) Limore, M	n D	
otified at	Director	10a. State 10b. County	imore	10c. City, Town or Lo ${f L}{f U}$	cation Ithei	ville					10	0d. Inside City Limits	
ust be n	Funeral D	10e. Street and Number 501 Brightwood	d Club Dı	rive		21093					What Count d Sta		
Important, I near 27 is marked other train makers 1, or terms zer of zoer 3 mo any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 I Yes, Give Year or Dates.	No	If Yes, spe	dent of Hispanic cify Cuban, Mes 2 <b>X</b> No Spe	kican, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - American Indian, Black, White, etc. Specify: White			
the Medica	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		(Give	kind of wo	nal Occupation ork done during e retired) emaker	most of work	ing			usiness Ind Home	ustry	
itic event,	To Be	17. Father's Name (First, Middle, Last) Thomas H. G.	Baillier	9				e (First, Middle n Rigg		Surnam	e)		
her trauma		19a. Informant's Name/Relationship (1 Thomas Daly-		7 St	oney		mber or Run	urt, I	er, City oi	rTown, S erv	State, Zip C ille,	, MD 2109	3
jury or oth		20a. Method of Disposition  1 X Burial 2 Cremation 3 C  4 Donation 5 Other (Speci	ify)	St. Mary	s (	cther place) Cemete	1 20	12	В	alt		e, MD	
any ir		21. Signature of Funeral Service Licen	naun	) 1	6924	York	Road	Monkt	on,	rem MD	ation 211		e.
dical dical	l Examiner	2 a. Patt 1. Enter the disease, or comshick, or heart failure. List only of the disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a c.			, .				m.		Approximate Interval Between Onter and Death	
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy   23d. Date of del										ry Day Year	_
ould be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the									ably 4 🗌 Unknow		
or, page 2 sh	Completed	25. Was case referred to medical				26 Diago of	Death (Chec	1 🗆 Yes	opsy ormed?			sy findings available npletion of cause of	
direct	To Be	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie		Other	_	ome 5 Res	idence (	6 🗌 Oth	er (Specify)		
the funera	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be			28b. Time of injury 28c. Injury at work?  M 28b. Time of 28c. Injury at work?  1  Yes 2  No						red		
illed in by 1		4 - Homicide determined	building, etc					City or To	ocation (Street and Number or Rural Route Number, City or Town, State)				
npleted f	Medical	(Check 2 Medical Exam	vician: To the best of hiner: On the basis of e rse Practioner: To the	xamination and/or inves	tigation, in	my opinion, dea	th occurred a	t the time, date	and place	e, and du	e to the cau	se(s) and manner sta	ted.
200		29b. Signature and title of certified	unni	7	29c. License number  D33400					29d. Date signed (Month, Day, Year) 06/06/2012			
12		30. Name and address of Gerson who Included WIG		path (Item 23a) (Type,		Charle	es st	reet b	alt	mu	e, 4	21212	
Stat egistra	e	JUN 0 7 2012	32. Registra	's Signature	•								

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Them 2b per doc 8928 6-7-12 vt. State of Maryland / Department of Health and Mental Hygiene for State Registrar 3003 Reg. No.20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Mer Month Physician/ 04:39 2012 26 Dorothy Mae Downer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 6. Sex If Under 1 Year If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Bel Air 7. Age (In vrs. last birthday) **Funeral** Hours 214-34-3875 1 🗆 M 2 🛛 F Director 76 Yrs March 11, 1936 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State be notified at Director 1 Yes 2 No or 28a-f Cecil colora Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21917 death with U.S.A. 1950 Liberty Grove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. by "natural", or 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fibewood Arsenal - Secretary Covernment 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glalys Rell Campbell ည Oliver Arch Mank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1950 Liberty Grove Road, Colora, Maryland 21917 Mr. Calvin Walker Downer (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Menorial Gardens May 31, 2012 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Jeffrey R. Testerman 22. Name and Address of Facility
Evans Funeral Chaptel & Cremation Service — Bel Air
(M01543) 3 Newport Drive, Forest Hill, Maryland 21050 Signatu**9**e of Funeral Service Lice 23a. Part 1/Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SEPTIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Perforated Viscus Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 Dorothy IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 m hths? Month Dav Year 5 Other (specify) Downer Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ✔No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) moccoint264 examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a, Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural înjury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dec 56296 5-26-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr Belair, MB 21014 State Registrar

126

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar
Physician/ 1. Decedent's Name (First, Middle,Last) Reg. No. 3. Time of Death 2. Date of Death

edical Exami	ner	Diane Dredden		Ma	y 31, 2012		1325 hrs				
		4a. Facility Name (if not institution, give street and number)	4b. City, Town,	Town, or Location of Death 4c. County of Death							
		Mercy Hospital	Baltimore			N/A					
Funeral		Social Security Number	/) If Under 1 Ye	ear If Under 24Hrs. 8. D	ate of Birth (MM	1/DD/YYYY) 9. Birth	place (State or				
Director		214-56-8460	Months Da	Linuar Min	,	Foreign					
Director		1 M 2 F 60	Yrs.	2/	4/1952	Z Cou	ntry) MD				
		Usual Residence of Decedent									
na Vua		10a. State 10b. County 10c. City, Town or Lo					10d. Inside City Limits				
p Mod si	_	MD N/A Baltin	nore				1 X Yes 2 No				
Maryland 28a-f show d at once.	5	10e, Street and Number	10f, Zip Code		10g Cit	tizen of What Coun	rv?				
Mar da	व विक्रित 501 E. Preston St. Apt. 127 21218 U										
3a o											
with	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race-White, 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race- White, 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)										
leath r ite	The second of th										
fler de l'', or		3 Widowed 4 Divorced If Yes, Give Yeer 1	Yes 2 X	lo specify:		Specify: Bla	.ck				
irs a fura	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busin										
2 ho	15. Decedent's Education (Specify only highest grade completed)  16. Nind of Business and Coupation (Give kind of work done during most of working life. Do NoT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)										
36 lin 7 dical	12th N/A Unemployed N/A										
Me general S	12th N/A Unemployed N/  17. Father's Name (First, Middle, Last) Joseph H. Dredden, Sr.  18. Mother's Name (First, Middle, Maiden Surname) Margaret R. Young  19a. Informant's Name/Relationship (Type, Print) Michael Dredden-Brother  3410 Rosalie Ave. Baltimore, MF										
F B B B											
be intal	Be										
d M d	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Star										
AD 2 st	Michael Dredden-Brother 3410 Rosalie Ave. Baltimore, MD  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signifure of Funeral Service Licensee  22. Name and Address of Facility March F/H - East										
Heal Heal	Specify: 1   1   1   1   1   1   1   1   1   1										
MOTE Pages 1 nent of H ant: If it				Pk. 6/9/2	012 Da	ndalla±	OTTO MED				
Pa Pa tant		4 Donation 5 Other Specify.					OWII, MD				
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee	2. Name and Addre	ss of Facility Marc	h F/H	- East					
E.E.A.E	1.13			North Ave.			1202				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	ter the mode of dyin	g, such as cardiac or respi	ratory arrest, sh	lock, or heart	Approximate Interval Between Onset and				
Medical	1 //	Immediate Cause (Final disease a. Methadone Intoxicat	tion			13	Death				
Examiner		or condition resulting in death)  Due to (or as a consequence of):	LIOI								
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Ē	cause. Enter Underlying Cause									
8	if any, leading to immediate cause. Enter Underlying Cause (unsease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
ransi	d.										
Sox 68760, death certificate be executed the attending physician and office use as the burial - transit	yslcian/Medical	MUNPENDED AMENDED 23a,27,28a-f,	per me,g	928 <b>6-8</b> -12 s	m.						
30, te be ty sic	9	IF FEMALE: 23c, If yes, outcome of pregnancy			23	3d. Date of delivery					
87 ifica ig ph	E	23b. Was decedent pregnant in the	Fetal death 3	Ectopic pregnancy		Month Da	ay Year				
cert cert use a	S.	past 12 months?  4 Pregnant at time of death	Other (Specify)								
Box 68760, death certificate be he attending physic of for use as the bur	ys	1 Yes 2 No 9 ✓ Unknown 9 Unknown	O								
s, P.O. B nires that the de signed by the d be detached if	됩	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause	given in Part I. 2	3e. Did tobacco	use contribute to the	ne cause of death?				
P. Grithat	۵				1 Yes 2	No 3 Proba	ibly 4 🗸 Unknown				
S, quire an sig	Completed				4a. Was an	24h Were out	ppsy findings available				
W rec	음				autopsy	prior to co	mpletion of cause of				
ec ne la te hz	Ĕ			1	performed? ✓ Yes 2 N		2 No				
tal Records cian: The law requir certificate has been s ector, page 2 should											
Vital Rec ysician: The I his certificate I director, page	å	examiner? Hospital:		Othor: —	(11111)	ence 6 Other:					
Phys	The state of the s										
Aft.											
tten ften death											
Vis Per A Direction by	追	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Rout									
Division pital or Attencours after death neral Director:	F	Residence   Specify   Could not be determined   (Specify)   Could not be determined   (Specify)   Residence   Could not be determined   (Specify)   (Specify									
Hosp 24 ho Func ely f.											
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medicel Examiner:On the basis of examination and/or invest									
THE BE	ě	29b. Signature and title of certifier	29c, Licer	nse number	29d.	Date signed (Mont	h, Day, Year)				
	_	110 1 (1 1)		.M.E.	l .	ne 1, 2012					
		Melle Drull, 100	L	vi.L.							
d	- 1	30. Name and address of person who completed cause of death (Item 23a)									
V		Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									

State

32. Registrar's Signature

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-04275 State of Maryland / Department of Health and Mental Hygiene Charles Vernon Fell 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Da June 5, 2012 1656 hrs Charles Vernon Fell **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 1618 Popland Street N/A If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Min. Months Days Hours Country) Maryland Director 219 01 4774 90 12/04/1921 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State **Baltimore** 1 X Yes 2 No N/A Maryland narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. saltimore, MD 21215-0036

rmit. Pages I and 2 should be filed within 72 hours after death with the Maryland partnern of Health and Mental Hygiene.
portner: If litem 27 is marked other than "natural" portner. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 21226 1618 Popland Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married 1X Yes 2 - No White Yes, Give Year WW 1 Yes 2 X No specify. Specify: 3 Widowed 4 Divorced II 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Iona Miller Joseph Jerome Fell Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, Maryland 21060 Anna G. Wayne / Daughter 116 Oak Spring Drive 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 06/08/2012 Baltimore, Maryland Bayview Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Se Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway Approximate Interval 23a. Part I. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. **(Medical** Death a. Intracerebral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical attending physician a for use as the burial -AMENDED UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Month 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24h Were autopsy findings available prior to completion of cause of autopsy icate has b page 2 sh death? performed? Yes 2 No 1 Yes 2 No this certificate 26 Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes After 1 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c, Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification 1 V Natural 1 Yes 2 No Pending To the Hospital or within 24 hours after death
To the Funeral Director the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

641

State Registra

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

Assistant Medical Examiner

and manner stated

29c. License number

O.C.M.E.

OUME

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

June 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			state Amend Item 27 per dr., Registrar	g928,06/06/12012-11-10-10	Reg.	No.2012	18006
	Physicia Medic		1. Danedent's Name (First Middle Last)  Philis Rebecca 1	Foster	2. Date of Death Month	Day Year	3. Time of Death 5:30 PM
	Examir	er	4a. Facility Name (If not institution, give street and number)  SIMA HUSPITAL OF	BAUTIMINE BAUTIMOR	A 1	4c. County of Deatl	h
	Funeral Director		5. Social Security Number 6. Sex 7. Age 15/-48-8359 1 M 2 F Usual Residence of Decedent	e (In yrs. last birthday)  If Under 1 Year If Under 24 Hr Months Days Hours Mir		r) Cou	thplace (State or Foreign untry)
	aryland a-f show fied at	Director	10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  To filedith and Mental Hygiene.  To filedith and Mental Hygiene.  To ther traumatic event, the Medical Examiner must be notified at		10e. Street and Number	OSS Drive 21207	10g.	Citizen of What Co	
	er death or items	by Funeral	11. Marital Status  1	Ever in U.S. 13. Was Decedent of Hispanic Origin? (6) If Yes, specify Cuban Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
CCA 215-0036	72 hours after n "natural", or	eted b	3 ₩Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:	Lan	Specify: 3/	ack
92945	ed within 72 h Hygiene. other than "n ent, the Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5-	(Give kind of work done during most of we	forking 160	Factor	ndustry
1 Reb	should be filed vand Mental Hygis marked otheraumatic event,	To Be	17. Father's Name (First, Middle, Last)  Mac Moody		lame (First Middle, Maide	1	7
O E	and 2 should Health and Me em 27 is mar ther traumati		19a. Informant's Name/Relationship (Ty e, Print),	19b. Mailing Address Street and Number or F			2 ./
TSS to	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition  1 Method of Disposition  1 Description of Disposition	20b. Plage of Disposition (Name of cometery, crematory of other place)	Date 20c	Location - City or	Town, State
17 E	permit. Page Department Important: any injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		wene Fune	MD 21133
	Physician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not enter the mode of dying, such as cardie	ac or respiratory arrest,	1/	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a consequence of):  ONTIC STENOSIS			MONTHS
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence oil.			
_	ificate be executed ig physician and as the burial-transit		that initiated events  c. Due to (or as a Due to (or a) Due to (or a				
8760	) <u>4</u>	Medical	IF FEMALE:				
Box 6	ath cer attendi for use	Physician/	23b Was decedent pregnant 23c. If yes, outcome of	2 Fetal death 3 Ectopic pregnancy		23d. Date of deli Month	ivery Day Year
O d	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions contributing to death bu	ut not resulting in the underlying cause given in Part I.  TOTABETES MELLITY)			the cause of death?
Vital Records	The law req ate has bee page 2 sho	Completed	17 YPERLIPIDEMIA		24a. Was an autopsy performed? 1 \(\sum \) Yes 2	prior to c death?	copsy findings available completion of cause of
C it	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Ch		NOT TESTES	2 🗆 140
A C	ding Phys h. After this funeral di	ate: To	1  Yes 2  1  1	y 28b. Time of 28c. Injury at	Home 5 Residence 28d. Describe how inj		<u>fy)</u>
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No  ry - At home, farm, street, factory, office . (Specify)	28f. Location (Street a		al Route Number,
	To the Hospital of within 24 hours a To the Funeral D completely filled it	Medical	29a. Certifier 1 Certifying Physician: To the best of r (Check 2 Medical Examiner: On the basis of ex	my knowledge, death occurred at the time, date and place kamination and/or investigation, in my opinion, death occurred	e, and due to the cause(s	) and manner as sta	ated.
	To the within 2 To the comple	Me	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	best of my knowledge, death occurred at the time, date and 29c. License number	place, and due to the cau	use(s) and manner as Date signed (Month)	s stated.  Dav. Year)
	0		30. Name and address of person who completed cause of de	path (Item 23a) (Type, Print)  SINAI Ho	430 M	AY 18	2012
	Stat	P	RAVITET KHUNKHU		SPITAL (	JE BAC	IIMONE
	Registra	ar	31. Date filed (Month, Day, Year) JUN 0 6 2012	A. barrel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 2012 Physician/ Month 10 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Medical llerzu 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 1 🗆 M 2 🗹 F or 28a-f show 10d. Inside City Limits 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No imore 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ and Mental Hygiene. is marked other than "natural", or Maryland 21215-0036 1 Yes 2 No Specify. Specify: Blac If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other မ 19b. Mailing Address (Street and Number or Rural Route Number, on Baltimore, Method Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Brooklyn MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licens 22. Name and Address of Facility avame O. Greene Funeval Services MU 01/33 Ustown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or head ailure. List only one cause on each line. Approximate Interval Retween set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical 3 years Examiner displaying the same of the sam Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of physician ar resulting in death) Last Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 2 🗌 No this certificate Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 1 Yes မ Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the russymmer death.

Within 24 hours after death.

To the Funeral Director. After th 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D56399 who completed cause of death (Item 23a) (Type, Print 301 ST. RWIST State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** Month 331 2012 une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agner Mospita rmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-05-23 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗷 F Hours 237.30-8704 8 Yrs. Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examination. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director +Imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? endale Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT, use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor autician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Armstrong RECKE ပ ONDO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Allendal Rd, Balto, MD 21216 mith 7801 Edna VIVIAN /daughter 0 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06-13-12 Woodlawn Balto, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility James A MORTON HSONS apres a. 1705 eurens Boilto MD 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cute and Physician Organi Zin broncho neumona /Medical Due to (or as a consequence of) Examiner horacic-abdominal gortic anguryim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Status-Post Due to (or as a consequence of): Examine Athenosclerosu burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE: Вох use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) O 9□Unknown requires that the 9 Unknown þ signed to be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes page 2 should Were autopsy findings available prior to completion of cause of certificate has autopsy performed? leath? Vital 2□ No 2 ☐ No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 0 this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Division or Attending Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi (Check only 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 900 Catan Autore - Beltimore, Mayland 2 1229 Jetifiret L. S 31. Date filed (Month Day, Year) · Seibel M.D. Ph.D. Saint Agnes Hospite | 32. Properties Signature M.D. State JUN 0 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Marylai		artment of F tificate of D	lealth and N	/lental Hy	giene Reg. No.2	012	18009	
		1. Decedent's Name (First, Middle,		1 E C		uncate or L	Jean	2. Date of De	eath		3. Time of Death	
Physic Med		Julie 3, 2012								Year	1:00 A M	
Exam	iner	4a. Facility Name (if not institution, Gilchrist Hospice							4c. Cou Bal			
Funera			6. Sex	7. Age (In yrs.	last birthday)	Towson  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi		9. Birth	place (State or Foreign htry)	
Directo		Usual Residence of Decedent	1 □ M 2 <b>XX</b> F	68	Yrs.			July 13	, 1943	MD		
iryland I-f sho ied at	ctor	MD 10b. County		10c. C	ity, Town or Loc						10d. Inside City Limits  XXX Yes 2 □ No	
the Ma or 28a e notif	Dire	10e, Street and Number 10f, Zip Code							10g. Citizen of What Country?			
h with ns 23a must b	Funeral Director	3200 Chestnut Avenu				212			U.S.A			
Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		11. Marital Status  1 XXVever Married 2  Married 3  Widowed 4  Divorced	Armed Fo	2 <b>XX</b> No /e	"	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2XXNo	spanic Origin? (Spen, Mexican, Puerto Specify:	14. Race - American Indian, Black, White, etc.  Specify: White				
5-00	plete	15. Decedent (Specify only highes	's Education			lent's Usual Occupa	ation furing most of work	ina	16b. Kind of Business/Industry			
rthan the Me	Completed by	Elementary/Secondary (0-12)	College (1		life. DO	NOT use retired) sembly			RBL	. Packag	e Display	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To Be	17. Father's Name (First, Middle, La	ast)				18. Mother's Nam			ame)		
ould be marke	-	John L. Garrett  19a. Informant's Name/Relationshi	p (Type, Print)		10b Mailin	a Address (Street	ETHEL I'M	arie Cumo		n State 7in l	Code)	
		David Garrett (Bro			1 .		d Sykesvil					
Baltimore, bermit. Page 1 and Department of Heal Important: If item:		20a. Method of Disposition  1XX Burial 2 Cremation		State		natory or other plac	e)	Date	1	on - City or To	own, State	
Baltimo permit. Page Department Important: I any injury o	ģ	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Furreral service of					Park   6/9/1 ss of Facility Burg		Elkrid	· .	Home Inc	
m Ferre	5	July C	Bul	٧	136	531 Falls R	oad Balto.	MD 212	11	unerar.		
Prysician		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final	nly one cause on ea	ach line.	CANO		g, such as cardiac (	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Medica Examine	al C	disease or condition resulting in death)	a	(or as a consec		<i>&gt;</i> E∼				-		
Examine		Sequentially list conditions, if any, leading to immediate couse Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
ransit	Examiner											
certificate be executed and ing physician and use as the burial-transit	dical E	resulting in death) Last	Due to	(or as a consec	quence of):							
3760 rificate by ig physic as the b	Medic	IF FEMALE:	d									
Box death ne atte ed for	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	nant at time of	etal death 3	Ectopic pregnand Other (specify)	у			Date of deliv Month	rery Day Year	
P.O. that the ned by the e detach	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions								ontribute to t	he cause of death?	
cords, I law requires t has been sign e 2 should be	ted by							1 🗆	Yes 2□N	o 3 🗆 Pro	bably 4 Kunknown	
as as	Completed							24a. Was auto perf 1 \sum Yes			psy findings available impletion of cause of	
rtal sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		7	Oth	ace of Death (Chec				Hosper	
of V  ig Phys ter this neral d	te: To	27. Manner of Death  1 Natural 5 Pending	28a. Date		ER/Outpatier 28b. Time of injury	28c. Injury	4 Nursing Ho	ome 5 ☐ Res 28d. Describe			y) stospico	
Sion ttendir death. stor: Af	Certificate:	2 Accident Investig 3 Suicide 6 Could n	ation ot be			M 1 🗆	Yes 2 ☐ No	28f Location	(Street and Nu	mher or Rura	l Route Number.	
DIVIS	Cer	4  Homicide determine		ing, etc. (Speci		set, lactory, office			wn, State)	mber of ridia	Troute Namber,	
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check 2 Medical Ex	caminer: On the ba	sis of examinati	ion and/or invest	tigation, in my opinio	e, date and place, a on, death occurred a he time, date and pl	t the time, date	and place, and	due to the ca	ause(s) and manner stated.	
To t To t		29b. Signature and title of certifier	chas			29c. License			29d. Date sig			
A		30. Name and address of person w				Print) SYED Q	ABBAS, MC		Owne	<u> </u>		
Si Regis	ate trar	31. Date filed (Month, Day, Year)		Registrar's Sign			,					
			100	-								

12-04219 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 18010 Glenn Allen George State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Da June 3, 2012 Medical Examiner Glenn Allen George 1915 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11 Walstan Avenue **Baltimore County** Reisterstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Director 218-78-4739 Hours 50 Oct 6 1961 1 M 2 F Country) MD Usual Residence of Decedent 10a. State 10d. Inside City Limits NO. 10b. County 10c. City, Town or Location Carrol1 Eldersburg 1 Yes 2 X No items 23a or 28a-f show ust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1682 Brimfield Circle 21784 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, traumatic event, the Medical Examiner must be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Y Never Married 2 Married 2 X No Yes of Health and Mental Hygiene.

If item 27 is marked other than "natural", or 4 Divorced f Yes, Give Yea Yes 2 X No specify: Specify: white 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 plumber plumbing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Gordon Lee George Sr. Be Norma Elaine Dennis 19a. Informant's Name/Relationship (Type, Print ) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1682 Brimfield Circle, Eldersburg, MD 21784 Kelsea E. George (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State All County Cremation 6 - 7 - 12Svkesville, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee (taiges)aught a terbers Box 195 Sykesville, MD 21784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b Choking on Food Bolus Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been suneral director, page 2 should Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? page ✓ Yes 2 No 1 Yes Hospital or Attending Physician: 25 Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) Unknown 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject choked on food bolus Natural Unknown death. Director: , d in by the fi 5 Pending 1 Yes 2 ✔ No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City hours after 3 Suicide Could not be or Town, State) 11 Walstan Avenue, Reisterstown, MD determined (Specify) Multi-Family Apt. 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 4, 2012

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ABOULLAH GHALZAI K. 2012 10:22 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13222 Greenmount Avenue Prince Georges Beltsville 5. Social Security Number 8. Date of Birth Sept 16, 1916 9. Birthplace (State or Foreign Country)
India If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Director 318-84-2312 1 X M 2 - F 96 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Beltsville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13222 Greenmount Avenue 20705 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Businesman Entrepreneurial 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ikhlas Khan Ramzan Begum 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jamila Iqbal Khan (Guardiah) 13222 Greenmount Ave., Beltsville, MD 20705 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lake View Mem. Park 6/8/2012 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Vicensee MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or combattions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DEBILITY Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending iniury 124 hours after death.

Funeral Director: After letely filled in by the fur work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 214774 6-5-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HWY, SHAHID AZIZ 445 DEFENSE H.D ANNAPOLIS Date filed (Month, Day, Year

DHMH 17 Rev 06-2011

State

Registrar

JUN 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lorraine Michealena Gettier Month 3:23 P.M 2012 Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Fallston ac. County of Death
Harford County 2109 ArdenDrive 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 212-32-5357 Director 1 □ M 2 🛣 F 77 12/15/1934 Maryland Usual Residence of Dec item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Harford County Fallston Maryland 1 Tes 2 No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funera 21047 United States 2109 Arden Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. \$ 1 Never Married 2 X Married 1 and 2 should be filed within 72 hours efter of Health and Mental Hygiene. Item 27 is marked other then "naturel", or 5-0036 1 Tes 2 No Specify: White Completed 3 Divorced 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Electrolux Receptionist 10 Be and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adam Silwick Emma Christine Cosgrove Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
632 Chapel Terrace, Havre de Grace, Maryland 21078 Janet Bohdel (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Pege 1
Department of
Important: If it
eny injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place) Evans Funeral Chapel 106/07/2012 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility
vans funeral Chapel & Cremation Serviœs-BelAir
Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the dise ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus-Immediate Cause (Final disease or condition resulting in death) Priysician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

1 Funeral Director After this certificate has been minned. been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery P.O. Box 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been significate has been significated after the second of 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Marther of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of dertifier 30. Name and add of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edwina 2-50 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K F Days Hours 11 - 11 - 12 1 9 20 91 New York **Director** 203-01-3619 Usual Residence of Decedent show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f st notified 1 Yes 2 X No MD Baltimore Co. Carney 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be Funeral 2514 Cub Hill Road 21234 USA items ; within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Midowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Secretary Army Intelligence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Samuel MacGregor Dora A. Pieper 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Gluth Jr.-Son 2055 Gough Street Baltimore, MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 0 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other placel Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cem. 6-6-2012 Dundalk, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and if for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No Dav signed by the at d be detached fo 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔂 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Yes 1 Manatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury death. 1 🗌 Yes 2 No within 24 hours after death

To the Funeral Director: a
completed filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the 9 29d. Date signed (Month, Day, Year) Terre 5 th 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock
Balling not Rd - 21239 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

/ 11 / 1001	012 180	ì	1
-------------	---------	---	---

No. Section   The Part   The Pa			1- For State Registrar	Certificat	e of Death		Re	g. No.				
Separate power power and a control of the power power power and a control of the power power power and a control of the power				ABBELL		·	Month	Day Year				
10   10   10   10   10   10   10   10					4b. City, Town,	or Location of Deat						
20.078-1896   Common   Configuration   Confi						Harford						
The control of the co				Foreig								
ARYLAND   HARFORD CO   EDGEWOOD   Top. Critical ord What Country?   Top. College of What College of What Country?   Top. Col												
20 12 Septiment   12 West December 1 Septiment   12 West December 1 Septiment   13 West December 1 Septiment   14 Race - American Indian, Busy, White, etc.   15 Record   15 R			10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits			
20 12 Septiment   12 West December 1 Septiment   12 West December 1 Septiment   13 West December 1 Septiment   14 Race - American Indian, Busy, White, etc.   15 Record   15 R	yland t-f sho	호				OD	110	o Citizen of What Cour				
1   1   1   1   1   1   1   1   1   1	he Mar 1 or 28a iffed at	Direct				1040			iu y ?			
Second   Continued   Continu	h with 1 ems 23s	eral	11. Marital Status 12. Was Dece	edent Ever in U.S. 13	3. Was Decedent of H	lispanic Origin? ( S	pecify Yes or No-	14. Race - Ameri	can Indian, Black,			
Second   Continued   Continu	er deat , or ite		1 Yes	2X No			, (100.)		CK			
Second   Continued   Continu	ours aft stural?	d by	or Dates:	e completed) 16a. Dec	cedent's Usual Occup	ation (Give kind of						
Patricia C. Harrell/Mother 728 Rainbow Ct Edgewood, Md., 21040  20a Place of Disposition (Name of Centerbery)  21 Signature of Disposition (Name of Centerbery)  22 Name and address of Facility  23 Name and address of Facility  24 Place of Disposition (Name of Centerbery)  25 Name and address of Facility  26 Place of Disposition (Name of Centerbery)  26 Place of Disposition (Name of Centerbery)  27 Name and Address of Facility  28 Name and Address of Facility  26 Place of Disposition (Name of Centerbery)  27 Name and Address of Facility  28 Name and Address of Facility  29 Name and Address of Facility  20 Name of Death (Proposition)  21 Name of Death (Proposition)  22 Name and Address of Facility  23 Name and Address of Facility  24 Name of Death (Proposition)  25 Name and Address of Facility  26 Name of Death (Proposition)  27 Name of Death (Proposition)  28 Name of Death (Proposition)  29 Name of Death (Proposition)  20 Name of Death (Proposition)  21 Name of Death (Proposition)  22 Name of Death (Proposition)  23 Name of Death (Proposition)  24 Name of Death (Proposition)  25 Name and Address of Facility  26 Name of Death (Proposit	N 2 =	ete	Elementary/Secondary (0-12) College (1-	4 or 5+)		fe. DO NOT use ret	ired)					
Patricia C. Harrell/Mother 728 Rainbow Ct Edgewood, Md., 21040  20a Place of Disposition (Name of Centerbery)  21 Signature of Disposition (Name of Centerbery)  22 Name and address of Facility  23 Name and address of Facility  24 Place of Disposition (Name of Centerbery)  25 Name and address of Facility  26 Place of Disposition (Name of Centerbery)  26 Place of Disposition (Name of Centerbery)  27 Name and Address of Facility  28 Name and Address of Facility  26 Place of Disposition (Name of Centerbery)  27 Name and Address of Facility  28 Name and Address of Facility  29 Name and Address of Facility  20 Name of Death (Proposition)  21 Name of Death (Proposition)  22 Name and Address of Facility  23 Name and Address of Facility  24 Name of Death (Proposition)  25 Name and Address of Facility  26 Name of Death (Proposition)  27 Name of Death (Proposition)  28 Name of Death (Proposition)  29 Name of Death (Proposition)  20 Name of Death (Proposition)  21 Name of Death (Proposition)  22 Name of Death (Proposition)  23 Name of Death (Proposition)  24 Name of Death (Proposition)  25 Name and Address of Facility  26 Name of Death (Proposit	-003 I within giene.	E O		BUS	ВОҮ	18 Mother's Name	e (First Middle M		'S			
Patricia C. Harrell/Mother 728 Rainbow Ct Edgewood, Md., 21040  20a Place of Disposition (Name of Centerbery)  21 Signature of Disposition (Name of Centerbery)  22 Name and address of Facility  23 Name and address of Facility  24 Place of Disposition (Name of Centerbery)  25 Name and address of Facility  26 Place of Disposition (Name of Centerbery)  26 Place of Disposition (Name of Centerbery)  27 Name and Address of Facility  28 Name and Address of Facility  26 Place of Disposition (Name of Centerbery)  27 Name and Address of Facility  28 Name and Address of Facility  29 Name and Address of Facility  20 Name of Death (Proposition)  21 Name of Death (Proposition)  22 Name and Address of Facility  23 Name and Address of Facility  24 Name of Death (Proposition)  25 Name and Address of Facility  26 Name of Death (Proposition)  27 Name of Death (Proposition)  28 Name of Death (Proposition)  29 Name of Death (Proposition)  20 Name of Death (Proposition)  21 Name of Death (Proposition)  22 Name of Death (Proposition)  23 Name of Death (Proposition)  24 Name of Death (Proposition)  25 Name and Address of Facility  26 Name of Death (Proposit	215 215 be filed riked of	Be	, , , ,					•				
Table   Tabl	D 21 should I nd Men	ပ	19a. Informant's Name/Relationship (Type, Print )	19b. M	Mailing Address (Stre	eet and Number or						
Table   Tabl	and 2 stealth a			ther 728	Rainbow Disposition (Name of c	Ct., Edge emetery,			Town, State			
22. Signature of Funeral Service Licensee  22. Name and Address of Facility 23. SPHILADELPHIA BLVD., ABENDED,  23. Part I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  23. Part I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  24. Immediate Cause (Final disease)  25. Equation of the part of th	nore ages 1 nt of H			iii olale		06	00 10	TTMONITIM	MADVIAND			
Physician (Michical Examiner)  23. P41 Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25. P41 Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25. P41 Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need that the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed not need to be	altin mit. P partme portar			DULANE	22. Name and Addre	ss of Facility	ITTV FIMI	TIMONIUM,	ADEODD D A			
Table   Color   Colo			1865		321 S PH	ILADELPHI	A BLVD.	ABERDEEN,				
Sequentially list conditions as on condition resulting in death)   Sequentially list conditions (any leading to immediate below to (or as a consequence of):			failure. List only one cause on each line.		nter the mode of dying	g, such as cardiac d	or respiratory arre	st, snock, or neart	Between Onset and			
Sequentiarly its conditions.    Does to (or as a consequence of):	Examiner	i										
Color   Colo		_	Sequentially list conditions,									
Color   Colo	8	mine	cause. Enter Underlying Cause (Disease or injury that initiated									
Second Part	ansit de de		events resulting in death) Last Due to (or as a	consequence of):								
Second Part	e execucian an rial - tr	dical										
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	760 ficate b g physicate butthe butthe butthe butthe	≥	73h Mas decadest progress in the		7				. V.			
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	x 68 th certif tending	iciar	past 12 months?		=	Ectopic pregna	ancy	Month D	ay fear			
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	. Bo he deat y the at	hys	Ulkilot		the underlying course	given in Red I	23a Did tah	acco usa contributa to t	he cause of death?			
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	P.O es that 1 gned b	à	The second secon	death but not resulting in	the diderlying cause	given in Fait i.	_					
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	rds, requir been s	letec										
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Reco	dmo				<del></del>	perform	ned? death?				
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	tian: 1	0	eyaminer?									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Physical this eral dir	욘	1 ✓ Yes 2 No									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	OD C ending ath. or: Aft	tion	1 Natural 5 Pending May 17, 2			_			9			
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	The state of the s											
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ospital hours hours y filled		29a Certifier				1361 Brass Mil	Road Suite B, Belca				
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	thin 24 the Fr	dica	one) 2 Medical Examiner:On the basis of	f examination and/or inve								
OCME   lune 3 2012	# 1 1 8 1 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	Me		1				29d. Date signed (Mon	th, Day, Year)			
fre on Many			L V	9	0.0	.M.E.		June 3, 2012				
30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223					00 W. Baltimore	Street, Baltimo	ore, MD 21223	<del></del> 3				
State 31. Discribed (Month, Cen Year) 32. Registrar's Signature				gistrar's Signature		,	, =					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2254 Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** Carroll Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Yea Dec 29 219-30-7218 81 1930 Director 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location death with the Maryland items 23a or 28a-f sho her must be notified at Director Finksburg MD Carrol1 1 🗆 Yes 2 🗆 XNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21048 Funeral 2426 Kays Mill Road 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status Examiner Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) If Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) clerical secretary event, t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental I tem 27 is marked o Josephine Faye Cunningham ည Arthur D. Gans Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2426 Kays Mill Rd., Finksburg, MD 21048 19a. Informant's Name/Relationship (Type, Print) Barbara Smith (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, MD 6-1-12 Olivet Cem. 4 ☐ Donation 5 ☐ Other (Specify) Mt. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Harge Box 195 Sykesville, MD 21784 P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury ed diverticulitis To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events the burial-tra multiorgan Failure resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performe death? 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital 2 No ၣ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of

0

State

Registrar

tephan

31. Date filed (Month. Day

**JUN 0** 7

MD FACS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephan Itochuli 1380 Progress Way

32. Registraris Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2<sup>Day</sup> Physician/ Elizabeth N. Helinski Month 2012 19:19 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford Courty Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours 216-36-8810 72 06/20/1939 **Director** 1 □ M 2 🛛 F Maryland Usual Residence of Decedent 28a-f shov 10b. County items 23a or 28a-f sho ner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Maryland Harford County Abingdon 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 803 West Baker Avenue 21009 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Baltimore County life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Credit Union 12 Secretary filed wit al Hygier 1 other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental i Anthony F. Helinski Stella J. Gromacki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 7 Bailiffs Court Unit 201, Timonium, Maryland 21093 Gail Feland (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel 06/06/2012 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services-Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 13 CUT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death -Physician/ probable disease or condition Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypeclipidemie Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop 2 No 1 🗌 Yes Vital funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Division ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A: within 24 hours after or To the Funeral Direct completely filled in by 4 - Homicide determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) Q 500 upper Chesapente De Sacrueto Jr MD

Registrar
DHMH 17 Rev 06-2011

State

: n5

MSDO

32. Regis rar's Sig

2012

JUN 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2012 Elizabeth M. Hilseberg 9:35A M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris Hospice Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Country) 93 215-01-8418 Director 1 □ M 2XX August 19, 1918 Maryland 10d. Inside City Limits 28e-f shov 10h Count 10c. City, Town or Location th end Mental Hyglene. 27 is merked other then "naturel", or items 23a or 28e-f shor treumetic event, the Mealcyl Evanime must be notified at Director Baltimore Baltimore 1 Yes 2XXNo Maryland 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? 21236 Funeral 13 Fullerton Heights Avenue United States of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black. White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White 3 XVidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b Kind of Business/Industry (Specify only highe est grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 9:85 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Should be Department of Health and Menta Importent: If item 27 is merked eny injury or other treumetic anongo. ഉ Anna Hebbel August Leimkuhler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Silvage Rd., Baltimore, MD 21236 Joseph A. Hilseberg, Sr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State June 6, 2012 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services—Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) After this certificate has been signed by the ettending physicien end signeral director, page 2 should be detached for use es the burlel-transit Cause (Disease or injury that initiated events resulting in death) Last HILSEBERG Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 < or Attending Physicien: The law requires that the death certificate be yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant of times IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ELIZABETH Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy outope, performed: 2 **K** No 1 Yes 2 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) HOSPICE Hospital 1 ☐ Yes 2 🕱 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The best of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JACKIE JONES, CRNP

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

IUN 0 7

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend item 29c per doc e928 6-12-12 yt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Aast) 2. Date of Death Physician/ mar Medical 4a. Facility Name (if not institution, give **Examiner** anguallytown 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Director 212-58-2690 12M 2 F 2419 NC Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: if item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Baltimore Randallstown 1 ☐ Yes 2 ☐XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3430 Carriage Hill Circle, Apt. 102 211.33 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Completed by Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: African-American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Military US Government Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William P. Hyman Sr. Ruby Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra W. Hyman/Wife 3430 Carriage Hill Circle, Apt. 102, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s
Department of I
Important: if ite
any injury or ot Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 6-12-2012 Owings Mills, MD 21. Signature of Funeral Service-License 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1emol/naa disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine thematosis Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has hear along the tendent. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown surpher Vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Un atural 5 D Pending ours after death. erai Director: Af filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 111 D-54181 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jayne Jamieson Huck 2012 4:42 P.M Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) April 2, **Funeral** 9. Birthplace (State or Foreign 171-34-7035 Director vest chester. 1 🗆 M 2 🖾 F 69 Pennsylvania 1943 permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is merked other then "natural", or Items 23e or 28a-f show any highry or other traumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Towson Baltimore Maryland 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21286 934 Cromwell Bridge Road America 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Š Baltimore, Maryland 21215-0036 white 1 Tes 2XXNo Specify: 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Greater Baltimore (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical Technologist Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Wilson Samuel David Jamieson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Huck/ daughter 1609 Templeton Road Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of June Bate 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of uneral Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.
2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician/ Onset and Death BRAIN CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown 3 - Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by **Completed I** 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) in 24 hours area.

the Funerel Director. After this contacting the funeral director. ဂ္ 1 Tes 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medica To the Hosp within 24 hou To the Fune completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifie 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Day RANDOLPH LUTHER Medical 12:10 a<sup>M</sup> JUNE 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOSEPH RICHIE HOSPICE BALTIMORE . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) Director 212-46-2161 1 X M 2 □ F Yrs 66 Usual Residence of Decedent SEP. 12 1945 MARYLAND flad within 72 hours after daath with the Maryland in than "natural", or Items 23e or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MARYLAD BALTIMORE 1 Yes 2 XNo WOODLAWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7104 HULL CT. 21244 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Š 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced If Yes Give Completed Specify:BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiana. Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs 12yrs ASST'N STORE MANAGER WAL-MART permit. Paga 1 and 2 should ba filad w Depertment of Haalth and Mantal Hygi Important: If Item 27 is merked other any injury or other traumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ALBERT JOHNSON SR. MARIE MATTHEWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucretia Johnson/Wife 7104 Hull Ct., Baltimore, Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Dother (Specify) ARBUTUS MEMORIAL 06-08-12 BALTIMORE, MARYLAND 21. Signature of Funeral Services in the 22. Name and Address of Facilit WILLIAM C BROWN IZUG W NORTH A ÖWN COMMUNITY FUNERAL HOME P.A. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Oriset and Death disease or condition resulting in death) CARDIOMYOP Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ettanding physician end for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 **B**) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month been signad by tha e should ba datachad 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician; funaral director, 25. Was case referred to medical of Vital Certificate: To Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

complataly filled i Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge ideath occurred at the time, data and place, and due to only one 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Shirley S. Jones 2012 June 4 21:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Age (In yrs. last birthday) **Funeral** 8. Date of Birth 75 Yrs Oct. 17, 1936 1 M 2 X F Min **Director** 217-34-3800 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🗓 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21220 1 Mersy Court, Apr F USA Was Deceded Armed Forces? Ves 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hyglene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Laboratory Technician Mercy Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Barmen Sara Sher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Alton Court Rosedale, Maryland 21237 David Jones / son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗌 Burial 2 첩 Cremation 3 🗌 Removal from State permit. Page Department Important: If any injury or Metro Crematory, Inc. 06/06/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Stephanie Custer 22. Name and Address of Facilit Cremation Society of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 KIN 25. Was case referred to medical | a 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending ours after death.

eral Director: Al
filled in by the ft 1 Yes 2 No Investigation 2 Acciden
3 Suicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHIPG Zelia

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2012 Year Edwin William Jeffries 5 June 11:09a /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Carrol1 Examiner 4b. City, Town, or Location of Death Carroll Hospital Center Westminster 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 ₩ M 2 □ F 271-60-4519 51 Director OH <u>July 14 1960</u> Usual Residence of Decedent death with the Maryland 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination must be revisibled at 10c. City. Town or Location 10d. Inside City Limits MD Carroll Eldersburg Director 1 ☐Yes 2 🛛 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21784 6592 Allen Road USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1979 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1979-72 hours after 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1983 1 □Yes 2 No Specify þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatic event, the once. clerk Safeway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Jeffries Martha Leone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ann M. Jeffries (spouse) 6592 Allen Rd., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☑ Cremation 3 ☐ Removal from State Garrison Forest Vet. 6-13-12 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Buan L Haugh MO0764 |P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of yeach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) minute 5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗌 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate 2 No 2 □ No 1 □Yes 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

death. 24 hours after death Funeral Director: completely filled in by within 2.

Registrar

determined

4 Homicide

(Check only one)

29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00051924

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

meachester mo21102, Herbert P. Henderson J. mp 3 Mancheste

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death Time of Death Physician 1105 PM NIVIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Director March 6,1924 101-18-8460 Va Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show iral", or Items 23a or 28a-f sho Examiner must be notified at 1 TXYes 2 □ No Director MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21213 USA 25th St. Funeral 1748 E. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 XNo Black þ Specify: 3 Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within hand Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12th House Wife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Edward Goode Annie May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s f Health ar item 27 i Joseph L. Jordan/ Son 3949 Eitemiller Rd. Balto. Md 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 Important: If it any Injury or o once, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenmountCrematory June7,2012 Balto. Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** one hour disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Now MEW 11 H 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a . autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. of Vital Records. To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Division

within 72 hours after

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) MAY 30, 2012

31. Date filed (Month, Day, Year)

29a. Certifier

(check only one)

Medical

State Registrar

DEM JHBMC 32. Registrar's Signature

MID

and manner stated.

ne and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 6 ay Month Jenkins 20 F2 Joseph 2:25 рм J. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore 2711 E. Monument 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birting. Country) MD Months Days Hours 2/18/1951 216-52-3079 Director 1 X M 2 🗆 F Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 21218 927 Montpelier St. Funeral USA 12. Was Decedent Ever în U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc 1 Never Married 2 Married ģ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) N/A College (1-4 or 5+) Elementary/Secondary (0-12) 10th Laborer Beth. Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Forrest Margaret Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Jenkins-Daughter 927 Montpelier St. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Greenmount Cemt. 6/6/2012 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East Bearl. Mulin 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ NOU-Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ be detached for in the past 12 months? Pregnant at time of death Month Day 🗌 Yes 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ILETASTASES 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spe 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 1 within 2 To the 1 only one 29b. Signature and title of certifie 30. Name and address of person who of death (Item 23a) (Type, Print) State

Registrar

5/26/13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18025 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ James William Kendrick 9:07 PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Raltimore Baltimoxe Cit n/a Of Hospital 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days (Month, Day, Year) Min Months Director 213-54-0958 1 X M 2 🗆 F 62 1/1/1950 New York Usual Residence of Decedent show 10b County 10c, City, Town or Location 10d. Inside City Limits 10a. State at **Funeral Director** notified 28a-f s 1 🗆 Yes 2 💢 No Baltimore Baltimore MD 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? must be 23a USA 810 Dorchester Road 21229 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status ral", or iten Examiner r Black, White, etc. Completed by 1 Never Married 2 Married Yes 2X No 2 should be filed within 72 hours after ifth and Mental Hygiene. 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 🗆 Widowed 4 🗆 Divorced JAMES! other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Repair Parts Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ENDRICK ပ Margaret Barber James W. McDermott, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other traconce. 6335 Orchard Club Drive, Apt. 002, Elkridge, MD Marsha Ann Kendrick / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 6/6/2012 Baltimore, Maryland Nonation 5 Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 1. Sid latu 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ day disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-tran Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) signed by the at I be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No Yes 12 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending 1 Natural 2 Accident
3 Suicide Investigation after death Could not be within 24 hours after des

To the Funeral Director

completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gretifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gretifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number MBBS 2012 S -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Robert Wallfar Krauss 6:20 p M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton 24510 Williston Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Months 284-12-3482 90 Director 1 【 M 2 🗆 F Dec. 27, 1921 Ohio Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State at Director notified 1 ☐ Yes 2X No Maryland Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or Funeral 21629 24510 Williston Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in 14. Race - American Indian "natural", or ite Armed Forces 1945-Black, White, etc 1 Never Married 2 X Married δ 1 Yes : Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Yes 2 No Specify. 1946 Specify: white 3 Widowed 4 Divorced Completed Year or Dates er than "natur , the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Universities & ntal Hygiene. ed other than event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Executive & Scientist <u>Scientific Orgs</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) alth and Mental H 27 is marked of er traumatic ever ည Wallfar Gratifer Krauss Emma Elanora Mueller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marilyn Krauss / wife 24510 Williston Road Denton, Maryland 21629 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 06/06/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K. Taylor 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) Exami the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performe 1 ☐ Yes 2 🕅 No 1 Yes 2 X No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) ည Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 X Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number

A+1

Registrar

Avenue,

Georgia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10313

Weinstock

D0009748

6/05/2012

Suite 105, Silver Spring,

MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Ling Physician/ Month rederick Day 115PM Medical 4a, Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** County of Death everna Park Anne Rvema 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 07/28/1938 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) Funeral 1 X M 2 - F 73 Director 216 26 7121 Virginia Usual Residence of Decedent items 23a or 28a-f show er must be notified at 10a State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Glen Burnie 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Highland Drive Apt. 104 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ital Hygiene. ed other than "natural", or iter event, the Medical Examiner Black, White, etc. ģ 1 Yes 2 X No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Chemical Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) id Mental ! ပ James C. King, Sr. Edna Smith or other traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James King, Jr. / Brother 122 Edenderry Avenue Centreville, Maryland 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/05/2012 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or shock, or heart failure. List hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final Onset and Death hunic Obstructive Physician/ disease or condition Medical resulting in death) Luknown Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Box 68760 Condition death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h performed? Yes No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes မြ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ve 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan		artmeni <i>tificate</i>			nd M		21	112	18028
	Physicia	an/	Registrar  1. Decedent's Name (First, Middle, Las		2. Date of				2. Date of Dea June 4		Year	3. Time of Death 9:25 PM		
-	Medic Examir		Pauline 4a. Facility Name (if not institution, give		а те	wis	4b City 1	fown, or Lo	ocation of		Julie 4		y of Death	7.23 IM
and the	Examil	iei	Stella Mari					Timon		Death		40. 00011	,	imore
	Funeral		Social Security Number     6. S	ex 7. Ag	e (In yrs. la	ast birthday)	If Under		f Under 24 Hours	4 Hrs. Min.	8. Date of Birti (Month, Day			place (State or Foreign
6	Director	Г	216-58-1412 1 Usual Residence of Decedent	□ M 2 X F		99 Yrs.	Months	Days	louis		Nov. 1.		Ohi	
	show at	5	10a. State 10b. County		10c. Cit	y, Town or Loc	cation						1	10d. Inside City Limits
	Maryla 18a-f tified	rect	MD Balt:	imore	Т	imoniu	m							1 ☐ Yes 2🏋 No
	a or 2 be no	<u>=</u>	10e. Street and Number				10f. Zip					10g. Citizen of	What Cour	ntry?
	h with ns 23 must	Funeral Director	2300 Dulaney Va					210					SA	
	r deat		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣	Ever in U.S	3. 13. V	Vas Decede Yes, speci	ent of Hispa fy Cuban, f	anic Origir Mexican, I	n? (Spec Puerto R	ify Yes or No- ican, etc.)		ce - Americ ack, White,	
21215-0036	s afte ral", c Exam	Completed by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.	No	1	☐ Yes 2	X No S	Specify:			Specif	y: Wh:	ite
2-0	hour natur	olete	15. Decedent's E (Specify only highest gra	ducation		16a. Deced	lent's Usual			of working	a	16b. Kind of	Business/In	dustry
2	hin 72 ne. <b>than</b> '	mo	Elementary/Secondary (0-12)	College (1-4 or 5	ō+)	life. Do	O NOT use	retired)	ing most c	UI WUIKIII	9		0	II
2	ed wit Hygie other	Be C	12 17. Father's Name (First, Middle, Last)	N/A			Homem		O Mother	do Namo	/Eimt Middle	Maiden Surnan		Home
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	Jerome Pahl						Em		Cortai		10)	
ary	hould and M is ma	١.	19a. Informant's Name/Relationship (7)	rpe, Print)		19b. Mailin	g Address	Street and	d Number	or Rural	Route Number	; City or Town,	State, Zip (	Code)
Σ	ealth am 27 in er tra		Paula Scheye/Dau	ghter		110	Beec	h Hil	1 La	ne	Towson	, MD 21	286	
ore	t of H		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State		Place of Disportence	sition (Name natory or oti	e of her place)	J	une	ate 6,	20c. Location	-	
Baltimore,	it. Pag rtmen rtant: njury		4 Donation 5 Other (Specif	y)	At	lantic				201	2	Glen B		
Ba	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licens	ehael J. I	lagl	e $egin{bmatrix} rac{22}{L} \ 1 \end{bmatrix}$	emmon 0 W.	Fune Fune Padon	ral ia R	Home oad	of Du T <b>i</b> mon	laney V ium, MD	alley 2109	Inc.
			23a. Rart 1 Finier the disease, or compshock, or heart failure. List only o	olications that caused ne cause on each line	d the deatl e.	h. Do not ente	r the mode	of dying, s	such as ca	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
2	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	2MC	enti	9							Oliget and Beatin
And of	Examiner			,	a oonseqt	ichiec oi).								
,	7 = =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):								
IDA	te be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience off:							-1	
·	be ex	dical E	resulting in deathy East	200 10 (01 00	a 001100q0	201100 0171								
376	eath certificate b attending physid for use as the b	Nedi		d				_				1		
39 ×	endin r use	an/N	Zob. Was decedent pregnant	23c. If yes, outcome			Ectopic pr	regnancy				23d. D	ate of deliv	
Bo	t the death by the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4 Pregnant a 9 Unknown			Other (spe					N	onth	Day Year
ision of Vital Records, P.O. Box 68760	that the ned by e detac		Part II. Other significant conditions of	ontributing to death b	out not res	ulting in the u	nderlying ca	ause given	in Part I.		23e. Did to	bacco use cor	tribute to th	ne cause of death?
ls, l	uires then signer and be	Completed by									1 🗆 \	es 2X No	3 🗌 Pro	bably 4 🗆 Unknown
Sor	as been si 2 should	plet									24a. Was a			psy findings available mpletion of cause of
Rec	The law ate has page 2:	Som									perfo	ned? 2 No	death? 1 Yes	
tal	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:					of Death	(Check o	only one)			
Ž	Phys this c	2	1 ☐ Yes 2 X No  27. Manger of Death			ER/Outpatien 28b. Time of		Other: c. Injury at	$\overline{}$			ence 6 Ot		·
o uc	Attending P death. ctor: After t y the funer	cate	Natural 5 Pending Accident Investigation	(Month, Da		injury	M  20	work?	s 2 🗆 N		od, Describe III	ow injury occur	164	
Division	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At ho	me, farm, stre	et, factory,	office		2	8f. Location (S City or Town		ber or Rura	Route Number,
Ö	urs aft ral Di		X	Ú.										
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in L	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examination only one) 3 Certifying Nurse	ner: On the basis of e	xamination	and/or invest	igation, in m	y opinion, o	death occu	urred at the	he time, date ar	nd place, and d	ue to the ca	use(s) and manner stated.
	To th Vithii Comp		29b. Signature and title of certifier		0 1	.0		License nu				29d. Date sign		
			- Una	X DNI	UN	17		2/30	X	1		6/0	120	12
			30. Name and address of person who carry TRACIE MORGAN,			. 23a) (Type, P <i>ANEY V.</i>		ROAD	) TI	MONI	UM, MD	21093		-
	Sta		31. Date filed (Month, Day, Year)	32. Registra				_						
	Registra	-11	JUN 0 7 2012 /	Greater J. C.	. 1	arkel								

PAULINE LEWIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items! per doc, 17,18 per fh g928 6-21-12 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** WILLIE BILEACH JR. 1: 39 A M 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XXM 2 □ F 247-86-9557 61 Director Nov. 19 1950 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1XXYes 2 □ No Directo BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21224 U.S.A. 420 N. LUZERNE AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22200 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc 1 ☐ Yes 2X If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married "natural", or Saltimore, Maryland 21215-0036 1 Yes 2 No à Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) marked other than N/A DISABLED 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida ISA BELL McDANIEL WILLIAM B. LEACH SR. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 420 N. Luzerne Ave., Baltimore, Md., 21224 Barbara Leach/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ō Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE CEMETERY 06-8-12 BALTIMORE, MARYLAND 21. Signature  $^{22}$  Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Bedlun 1206 W NORTH AVENUE 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final RESILATORY **Physician** FAILURE 2 Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 7 days SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Yes 2 □ No be detached P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has 1 ☐ Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ spital or Attending Phy.
nours after death.
neral Director; After this
filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 anagis Qa. Satos 31. Date filed (Month) 32. Regis Day, Year State JUN 0

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G928 6/22/2012 JH.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Medical Town, or Location of Death 4c Co 4a. Facility Name (if not institution, give street and number, of Death **Examiner** , /ver 1 7110 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs. If Under **Funeral** Hours Min. Director shington DC 28a-f show 10d. Inside City Limits 10b. 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Svitland Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 20 /, permit. Page 1 and 2 should be filed within 72 hours after death . Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes Specify 3 Widowed 4 Divorced 120 Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N -sovernmen Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mathis 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 4 Donation Other (Specify) 21. Sign up of Funeral Lice Licens 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e disease, or complications that caused the death. Do not enter the mode of dying, see as cardiac or respiratory arres Approximate Interval Between Onset and Death Immediate Cause (Final rdione Physician/ disease or condition resulting in death) Medical Due to (or as a monseque Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and for use as the burial-tran attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Other (specify) \_ Preg⊓aπ. □ Unknown been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No After this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes Manner of Death 28b. Time of 28d. Describe how injury occurred injury Natural Accider 5 Pending n 24 hours after death.

e Funeral Director: After bletely filled in by the fur 2 🗌 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, 29b. Signature and title of certifie 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For Amend It	ems 23a pe	Maryland / Depa r dr.,g928,0 <i>Cer</i>	tificate of	lealth a Death	ind Me	ntal Hygie	ne . No. 20	12	18031	
			Decedent's Name (First, Middle,					2	. Date of Death		Vanu	3. Time of Death	
	Physicia Medic		Clifford R. Ma	cklin				N	May 13,	2012	Year	6:45 a <sup>M</sup>	
Sec.	Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death								4c. County of Death		
and the			Prince Georges I		enter Age (In yrs. last birthday)	Chever If Under 1 Year	9	4 Hrs. Ω	. Date of Birth	Prince		rges lace (State or Foreign	
	Funeral Director		218-38-6873	1X M 2 □ F	70 Yrs.	Months Days	Hours	Min.	(Month, Day, Ye		Counti	ry)	
0	_ MC		Usual Residence of Decedent					Ma	ay 9, 19	942	Mary.		
	yland -f shc ed at	ctor	10a. State 10b. County  Maryland Prince	Georges	10c. City, Town or Loc						10	0d. Inside City Limits 1 ☐ Yes 2 X No	
	r 28a notifi	Dire	10e. Street and Number	Georges	Greini Dar	10f. Zip Code			100		Vhat Count		
	e filed within 72 hours after death with the Manyland happygiene. Hygiene ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11403 Old Prospe	ect Hill Ro	oad	20769				JSA	That Ooding	.,.	
	items items		11. Marital Status	12. Was Deceder	nt Ever in U.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origi	in? (Specify	y Yes or No-		e - America k, White, e		
36	after or I", or xamir	d by	1 ☐ Never Married 2 🕅 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1	☐ Yes 2 X No			,		White		
9	atura cal E	ete	15. Decedent	Year or Dates 's Education		lent's Usual Occur	pation		16	ib. Kind of Bu			
215	n 72 h e. ian "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed)  College (1-4 of	life DO	kind of work done O NOT use retired)		of working					
2	withi ygiene her th	ര	10		Sale	S	1			ro Sea		ndows	
Baltimore, Maryland 21215-0036	be filed lental Hy rked oth ic event	To B	17. Father's Name (First, Middle, La William Macklin	st)			1		irst, Middle, Mai Dlansky	den Sumame	)		
aryl	should be fill n and Mental 7 is marked raumatic ev		19a. Informant's Name/Relationship	p (Type, Print)	19b. Mailin	g Address (Street	and Number	or Rural R	oute Number, Ci	ty or Town, S	tate, Zip Ci	ode)	
Š,	ge 1 and 2 should be it of Health and Men If item 27 is marke or other traumatic		Sandra Macklin	/ wife	11403	01d Pro	spect	Hi11	Road G1	enn Da	ile,M	D. 20769	
ore	e 1 ar t of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3	3 ☐ Removal from Sta		natory or other pla		Date		c. Location -	-		
ţi	t. Pag ntment rtant: njury o		4 Donation 5 Other (Sp	ecify)	Metro Cre				2012 Ba				
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.		21. St., at re of inneral Service Lic	Cense Brephan		. Name and Addre 9 Freder						aryland,Inc 21228	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on		sed the death. Do not ente							Approximate Interval Between	
_	hysician/		Immediate Cause (Final disease or condition	End	stage He	nt fai	lure					Onset and Death	
7007	Medical Examiner		resulting in death)	Due to (or	as a c equence of): nic Kidney D								
		ler	Sequentially list conditions, if any, leading to immediate	b. ————	as a consequence of:	Theate					-		
	ited d ansit	Examine	cause. Enter Underlying Cause (Disease or injury	Morb									
	death certificate be executed ne attending physician and ed for use as the burial-transit	I Ex	that initiated events resulting in death) Last	Due to (or	as a consequence of):								
09		dical		d									
687	ertifica ding pl	/Me	IF FEMALE:	23c. If yes, outcor	me of pregnancy					00.1.0.4			
Box (	nat the death certifica ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 Live Birt	th 2 🗆 Fetal death 3 🗀	Ectopic pregnan Other (specify) _	су			Moi	e of delive nth	Day Year	
). B	the de by the ached	hysi	g Unknown	9 🗆 Unknow	/n								
P.0	gne be	ç								d tobacco use contribute to the cause of death?			
rds	require been si should	eted										ably 4 Unknown	
900	has b	Completed							24a. Was an autopsy performe	p	Vere autop prior to con leath?	sy findings available npletion of cause of	
Ä	ysician: The law is certificate has director, page 2		25. Was case referred to medical	1		26. D	lace of Death	(Chack or	1  Yes 2		Yes :	2 <b>T</b> No	
/ita	rsicia s certi direct	To Be	examiner?	Hospital:	patient 2  ER/Outpatier	LOtt	er.		5 Residence	e 6 🗆 Othe	er (Snecify)		
of	ng Phys ter this neral di		27. Manner of Death 1	28a. Date of			y at		d. Describe how				
ion	tendii Jeath. Ior: Af the fu	Certificate:	2 Accident Investigated Suicide 6 Could no	ation of he		M 1 🗆	Yes 2 1	_					
Division of Vital Records,	l or At after d Direct	Cert	4 Homicide determin	28e. Place of	Injury - At home, farm, streetc. (Specify)	eet, factory, office		281	f. Location (Stree City or Town, S		er or Hural i	Houte Number,	
	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	edical			of my knowledge, death of								
	<b>To the H</b> e within 24 <b>To the Fu</b> complete	Med	only one) 3 Certifying I		of examination and/or invest the best of my knowledge,	death occurred at	the time, date		, and due to the o	ause(s) and m	nanner as st	tated.	
	Voir Con		29b. Signature and title of certifier	L M.	0	29c. Licens	se number		290	I. Date signed	3 · 12	lay, Year)	
	(0)		30. Name and address of person w				374 6				1 6		
	10		Rowth Rank FAR	HIFAL	M.O. 12150	Anapolis	Road	Suit	200 61	endle	MO	20769	
	Stat		31. Date filed (Month, Day, Year)  JUN 0 7 2	2. Regi	strar's Signature	Kal							
	Registra	:11	JUN 0 1 L	VIL ARTH	- 1- 7	معيا							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 7:20°M LENN MAURICE MONTGOMERY JYNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN BETHESDA MONTGOMERY HOSPITAL If Under 1 Year If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 220-76-0970 **Director** 1 XM 2 🗆 F 52 FEB 20 1960 WASHINGTON OG Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City I lmits Director BETHESDA MD MONTGOMERY 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? ō must be Funeral items 23a 20814 U, S.A. GROSVENOR LANE 5721 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 27 is marked other than "natural", or itel traumatic event, the Medical Examiner Black White, etc. 1 XNever Married 2 Married by 1 Yes 2 No Specify: Specify: BLACK If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. COMPUTER Elementary/Secondary (0-12) College (1-4 or 5+) OPERATOR COMPUTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F JAMES R. MONTGOMERY 2 PATRICIA ANN PEACOCK Department of Health and Ment:
Important: If item 27 is marked
any injury or out. 19a. Informant's Name/Relationship (Type, Print) 🖟 🕻 🗸 🗸 🎁 THE 🤻 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONTGOMERY 4241 SYMMIT CORNER DrIVE FAIRFAX UM 22030 JASON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State AROENT CREMATION 6 /7 /2012 HANOVER MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bervis Licensee JOSEPH L. CANBY 22. Name and Address of Facility MARZYLLO FUNERAL CHAREL 6009 HARFORD ROAD. BALTIMORE . MD 21214 M00078 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart all we. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician/ METABOLIC ENCEPHALOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RENAL DISEASE ENO STAGE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner SICKLF CELL NERHROPATHY Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant In the past 12 months?
1 ☐ Yes 2 ☐ No Month a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC HEPATITIS C 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? SICKEL CELL CRISIS 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Montgomery, 5 Pending injury 1 X Natural Division Accident Sulcide Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 1000 armd D 17656 20814 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7830 GEORGETOWN RD TIPAPURN BETHESON MO WOODWARD, MO 31. Date filed (Month, Day, Year) State JUN 0 7 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 🗸 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 3:24 PM Physician/ Martha B. Pscherer Medical 4a. Facility Name (if not institution, give street and number) Town or Location of Death 4c. County of Death **Examiner** ace ao If Und If Unde 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Min. 1 M 2 X Hours 0872171923 Maryland 215-12-7842 88 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland must be notified at Director Maryland Harford County Bel Air 1 Yes 2 No 10e, Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral United States 21015 939 Whispering Ridge Lane items death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Home Maker 8 event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I ပ္ pe. Josephine Gioia Pasquale Amoroso permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1695 Bel Air, Maryland 21014 Deanna J. Wible-Gaddis 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Rosedale, Maryland Gardens of Faith 06/04/2012 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-BelAir 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam burial-transi emen and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Other (specify) 1 Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Dea . Check only one) 2 No Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: al or Attending P s after death. I Director; After t 5 Pending 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital of 24 hours at 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Prantioner To the best of my knowledge, death become diet the time, date and place, and due to the cause(s) and manner as water within To the 29b. Signature and title of certifier ပ  $\theta$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

ee\_

2012

31. Date filed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G928, 6/12/2012 WS
State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH G928, 6/18/2012 JH
Certificate of Death

Reg. No. 2012 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mary Evelyn Reed 0410 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agney Hospita Baltimore 5.992 Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex Age (In yrs. last birthday) -30 - 993779 Months Hours 1 🗆 M 2 🔀 F Director JAN 31, 1933 New York Usual Residence of Deced 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** items 23a or 28a-1 somer must be notified 1 🗌 Yes 2 💢 No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane HV619 21228 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ir than "natural", or iter the Medical Examiner þ 1 Never Married 2X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Registered Nurse Hospital traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ပ John Edward Connelly Mary Evelyn Doris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Francis Reed/husband 715 Maiden Choice Lane HV619 Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 № Burial 2 □ Cremation 3 🖫 Removal from State Arlington National 7/11/2012 Arlington VA ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Haight Funeral Home and Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 410-795-1400 Mc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Chaonic Physician Obstauctive Pulmonasy disease or condition eass Medical resulting in death) Due to (or as a consequence of): Examiner month ongestive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) for use as the burial-transi attending physician and Due to (or as a consequence of): Division of Vítal Records, P.O. Box 68760  $\ll$ Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aostic pertención, Stanosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 🗌 Yes Yes 2 V 25. Was case referred to medical examiner? Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MD 2549 31 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadipell MD21229 900 Avenue Baltimose 32. Re State Registrar

EED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 2012 Physician/ 9:15 Stanley Ruchlewicz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 168-38-2680 1 **X** M 2 □ F Director 56 DEC 27, 1955 Pennsylvania Usual Residence of Deced or 28a-f shov 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland aţ Director ral", or items 23a or 28a-f s Examiner must be notified Sykesville 1 🗆 Yes 2 🗖 No Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 610 Blankner Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐XNo If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) City Planning & Economic Development City of Westminster 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Florence Konczbwski Stanley Ruchlewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Blankner Road Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Lois Patricia Ruchlewicz/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 XI Cremation 3 ☐ Removal from State cemetery, crematory or other place) All County Cremation Services 6/9/12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Sin ature of Funeral Service Licenses Haight Funeral Home and Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ARRES ARDIA disease or condition Medical resulting in death) Examiner YEARS Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury INKruh or Attending Physician: The law requires that the death certificate be executed nroni attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown Month Dav Year Yes 2 No the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HY PERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed OBST RUCTUR SLED PAPARA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Vatural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be after death filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 death. within 24 hours a To the Hospital

> 5 State

completely

Medical

29a. Certifier

Michola J Date filed (Month, Day, Year) JUN 0 7 2012

3

29b. Signature and title of certifier

mich

Kohlerman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

6190 GEORGEROWA BIND SIDERS HIRS MO 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00037606

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Russell Day Physician/ Month 130 A 111 0 2012 Tunc 3 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death Examiner Ba Ih MOre HOSPITAL If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 215-54-1479 Director 1 □ M 2 🖵 F Dec.20,1949 MD 62 28a-f show 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Baltimore MD 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ò 23a Funeral 21213 USA Apt.202 1401 E. Oliver St. items 2 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ō δ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced "natural", Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Public School Retired Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theresa Whitehurst 2 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Albert Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6727 Collinsdale Rd. Rd Balto, Md. 21234 Michele Broom (niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) June 12,2012 ParkwoodCEM. Balto.Md. dure or pullal Servi Callyin Add Bs. of Schuggs Funeral Home Ε. Preston St. Balto, Md. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) cons quence of Due to (or as a Examiner Sequentially list conditions, if any, reading to infried late cause. Enter Underlying Examiner or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes & No 3 Probably 4 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes ate has bade 2 s this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 10 1 🗌 Yes 🖫 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After Natural 5 Pending work? 2 No the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signate 29c. License number 29d. Date signed (Month, Dav. Year) RES-000 2012

5

State Registrar 00

orleans st. baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Las 2. Date of Death 3. Time of Death **Physician** XUI0 /Medical 4a. Facility Name (If not in stitution, give street and n 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) Feb14, 1925 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min Poland 216-34-0019 87 Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location XXYes 2 □ No Directo City Md. Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 353 Cornwall Street 21224 U.S.A. **Funeral** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7th Clothing Seamstress 17. Father's Name (First, Middle, Last) (unk) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Be 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Rzepecki - Husband 353 Cornwall Street Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State JuneDate 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem 4, 2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA M00933 21. Signature of Funeral Service Ocense 1201 <u>Dundalk</u> Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause each ling Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse dence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Tetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day yes 2 No 9 Unknown 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ pe 1 🗌 Yes 2 No 3 Probably 4 Hunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 🗌 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \( \sum \) Nursing Home Hospital: No 1 Inpatient ၉ 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of eath Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year! Natural 5 Pending investigation (Month, Day Injury 1 ☐ Yes 2 ☐ No Accident ţ Director 3 🗌 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760, filled in by within 24 hours a the Hospital

> death (Item 23a) (Type, Print) 30. Name and

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature

31. Date filed

title of certifier

Day, 7 JUN O

and manner stated.

**ORIGINAL** 

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2-04168	_	Please Type or Print in Black Indelible				gible.	
ames Benjami	n Sc	- in any in the partition		nd Mental	Hygiene	201	2   803
Physici	anl	1- For State Certificate Registrar 1. Decedent's Name (First, Middle,Last)	or Death		2. Date of Dea	Reg. No.	3. Time of Death
ledical Exami		James Benjamin Scheff			Month June 1, 2	Day Year	2316 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town,	or Location of De		4c. County of Dea	th
		Bowie Health Center	Bowie			Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			Hrs. 8. Date of Bi	irth(MM/DD/YYYY) 9. B Fore	ian
		057-64-7731 1 1 M 2 F 33  Usual Residence of Decedent	Yrs.		May 9.	, 1979 °	ountry New York
any		10a. State 10b. County 10c. City, Town or Lo	cation				10d. Inside City Limits
Aaryland 28a-f show datonce,	ō	Maryland Prince George's Bowie					1 X Yes 2 No
Maryl • 28a-1	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho notified at once,	Μ	12003 Terra Lane	20715			USA	
ath wi	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of H If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	0- 14. Race - Ame White, etc.	rican Indian, Black,
fter de		3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X	lo specify:		Specify: Whi	te
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	d by	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> </ol>	dent's Usual Occup most of working li			16b. Kind of Business	
16 n 72 h	olete	Elementary/Secondary (0-12) College (1-4 or 5+)			eurea)		
5-0036 lled within 7 Hygiene. I other than	Completed	12 Elect	rician H		ma (First Middle	Construc  Maiden Surname)	<u>tion</u>
	Bec	James D. Scheff			Savares	,	
y, MD 2121 and 2 should be fi lealth and Mental tem 27 is marked traumatic event,	10	19a. Informant's Name/Relationship (Type, Print ) 19b. Mai	ling Address (Stre	eet and Number o	or Rural Route Nu	mber, City or Town, Stat	e, Zip Code)
MD and 2 sho alth and m 27 is remark		Gail M. Scheff/ Mother 1200  20a. Method of Disposition 120b. Place of Disp	3 Terra l	_ane Bow			
Baltimore, Dermit. Pages I at Department of He Important: If ite			oosition (Name of control of cont	- '	Date	20c. Location - City o	r Town, State
t. Pag tment tment rtant:		4 Donation 5 Other Specify: Huntt Cr 21 Signature of Funeral Service Licensee 22	ematory	6/	8/2012	Waldorf,	MD
Balt permit Depart Impor injury		ALU				Evans Fune	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	or the mode of dying	d DO 11S R g, such as cardia	c or respiratory an	e. MD 2071: rest, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a Methadone Intoxicati	on				Between Onset and Death
LAdillilei		or condition resulting in death)  Due to (or as a consequence of):					
	er	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):					
A >	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
ransit transit		events resulting in death) Last  Due to (or as a consequence of):  d.					
×	dical	■ MENDED 23a,27,28a-f,	per me,g	928 6-8-	12 sm		
Box 68760, death certificate be excheding physician of for use as the burial.	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy	_			23d. Date of deliver	у
OX 68 ath certifi attending or use as	cian	past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Other (Specify)	Ectopic preg	inancy	Month	Day Year
BOy e death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown	Other (Opcony)			1	
i, P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause	given in Part I.		obacco use contribute to	
ds, Faquires	ted				- 24a. Was		bably 4  Unknown utopsy findings available
COTC law re has be	Completed				auto		completion of cause of
of Vital Records, P.O.  ng Physician: The law requires that it ther this certificate has been signed by meral director, page 2 should be detac	S	25. Was case referred to medical	26 Dia:	a of Dooth (Choo	1 🗸 Yes	2 No 1 Y	es 2 No
/ital	Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatie		Other Nurs	sing Home 5	Residence 6 Othe	er:
of of ug Phy	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Month Day Year)		ury at Work?	1	how injury occurred	
ttendi death.	atio	Pending Investigation Fd 6-1-12 fd 10		Yes 2 X No	unknow	1	
Division tal or Attendir rs after death. al Director: A	Certification:	3 Suicide 6 X Could not be determined (Specify) Rack coast			or Town, S	State)13601 Woo	ural Route Number, City
Dir Lospital 4 hours at uneral I		4 Homicide 1992 Back Seat			Bowle, M	<u>ш.                                    </u>	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. After this certificate be expiral to the theory of the Adath. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	check only one)  2   Certifying Physician: To the best of my knowledge, death occuping one)  2   Medical Examiner: On the basis of examination and/or investignment of the basis of examination and or investignment of the basis					
7. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10	Me	29b. Signature and title of certifier	29c. Licer	se number		29d. Date signed (Mo	onth, Day, Year)
		Willia Brassell MD	0.0	.M.E.		June 2, 2012	
(1)		30. Name and address of person who completed cause of death (Item 23a)	\W D=#:-	Ctroni D "	MD 045	20	
Ψ ]	ate	Melissa Brassell, MD Assistant Medical Examiner 900  31. Date filed (Monte, Dax Year) 32. Registrary Signature		otreet, Baltim	iore, MD 2122	23	
Regis		31. Date field (Morry, Day Year)  32. Registrary Signature					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death June 2012 Physician/ 2:00 p M ANDREW STEVENSON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE CHASE 12132 EASTERN AVE. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Min Hours Director 220-22-6934 1 X M 2 □ F Yrs. 25 1926 85 OCT. MARYLAND Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2XXNo MARYLAND BALTIMORE CO CHASE 10e Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 12132 EASTERN AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates. 49/53 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CHASE ELEMENTARY Elementary/Secondary (0-12) College (1-4 or 5+) BALTO. CO. 12yrs <u>BOILER ENGINEER</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 OLIVER STEVENSON BETTY WILSON-EPPS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy B. Stevenson/Wife Eastern Avenue, Chase Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 Cremation 3 Removal from State Other (Specify) 4 Donation 5 MIDDLE RIVER, MARYLAND CEMETERY 06-11-12 21. Signature of a real Service 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME321 S PHILADELPHIA BLVD, ABERDEEN -HARFORD P MD 21001 Delaleur 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Ceath Immediate Cause (Final hronic Physician/ Clisesse disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ysician and e burial-tran Due to (or as a consequence of): Physician/Medical the b Division of Vital Records, P.O. Box 68760 attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy certificate has irector, page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funer completely filled in by the funer Natural Accident injury 5 Pending Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

the Hospital

Registrar

Medical

29a. Certifier

JUN 0

29b. Signature and title of

764

Namo

Name and address of person who competed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9512 Herford

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MD 21234.

Please Type or Print in Black Indelible Ink First Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ SMITH BERNICE 06 2012 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death 4b. City, Town, or Location of Do Examiner MD GOOD SAMARITAN HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 215-40-4277 Usual Residence of Decedent 72 Director 1 - M 2 F NC 12/24/1939 or 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits at Completed by Funeral Director notified BATIMORE MD 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be 21239 USA 1410 E. "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BIACK 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally nay niqury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hedwin CORP UPERVISOR Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NICE ပ Katliff Esther Sinclair permit. Page 1 and 2 should be Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LANE. PARMille. MD . 21234 Daughter 3031 Ratliff 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place BATIMORE, MD GARDEN 22. Name and Address of Facility Vaughn GREENE FUNETHI 3CKS 21. Signature of Funeral Sovice Licensee 4905 MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SEPTIL SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Month Day 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by YULMONARY EMBOUSM, CORONARY 1 Yes 2 No 3 Probably 4 Unknown DISEASE, ACUTE KIDNEY INJURY 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 ... 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred I Director: After the iniury 5 Pending work?
1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractificner: To the best of my horizon, death occurred at the firm date and place and do not be the cause(s) and manner stated. (Check within 2

To the F

complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06-04-2012 000 RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ABHISNEK SHARMA, 5601 LOCHRAVEN BLVD, BALTIMORE, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1700 PM **Physician** slie D. catton Mal 31 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center N/A Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛣 F PENNSYLVANIA Director 219-04-8885 29 1970 Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 X No Examiner must be notified Directo MARYLAND HARFORD CO STREET 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or U.S.A. 21154 924 COEN RD. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo þ 3 Widowed 4 Divorced Specify: BLACK "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " BALTIMORE CITY Elementary/Secondary (0-12) College (1-4 or 5+) 12vrs DIVISION CHIEF DISTRICT COURT other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked MICHAEL JACKSON ARDELLA PRIGG ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 924 Coen Rd., Street, Md., 21154 Ardella M. Jackson/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06-09-12 DULANEY VALLEY TIMONIUM, MARYLAND 21. Signature of For 22 Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S. PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure **Physician** Respiratory to Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumonia Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cancer Metastatic physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 □ Probably 4 □ Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has to autopsy 1 Tes ŏ Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: eral Director: After filled in by the funer 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

11595

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nti

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

31,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				artment of Health and Mental F	Hygiene
			Registrar  1. Decedent's Name (First, Middle, Last)	tificate of Death	Reg. No. 2  O G
	Physicia Medic		Mary Tamburrino	Month Ma y	27, 2012 3. Time of Death 1:30P. M
	Examin		4a. Facility Name (if not institution, give street and number) City	4b. City, Town, or Location of Death	4c. County of Death
			Morningside House of Ellicott	Ellicott City  If Under 1 Year   If Under 24 Hrs.   8, Date of	Howard
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 218-12-3186 1	Months Days Hours Min. (Month,	Day, Year) Country)
6			Usual Residence of Decedent		25,1924 Maryland
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner	Director	10a. State   10b. County   10c. City, Town or Loc   Md   Anne Arundel   Linthic		10d. Inside City Limits 1 ☐ Yes 2 <sup>X</sup> ☐ No
	the Ma or 28 e noti	Dir	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	n with	Funeral	504 Forest View Road	21090	U.S.A.
	r death or item iner n		11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Never Married 2 □ Married  1. □ Yes 2 ▼ No	Vas Decedent of Hispanic Origin? (Specify Yes or to Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
036	rsafte iral", c Exam	ed by		☐ Yes 2 🔀 No Specify:	Specify: White
15-0	"2 hou "natu edical	plet	(Specify only highest grade completed) (Give I	ent's Usual Occupation ind of work done during most of working	16b. Kind of Business/Industry
72	/ithin 7 iene. r than the M	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Offi	NOT use retired) Ce Clerk	Department of Defense
pu	filed val Hyg d othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mide	
ya	should be file and Mental F is marked o raumatic eve	ပ	Carl Sallese		Palladino
Baltimore, Maryland 21215-0036	2 ± 2 ±			g Address (Street and Number or Rural Route Nur $\operatorname{Green} olimits \operatorname{Bower} olimits \operatorname{Way} olimits \operatorname{El} olimits$	nber, City or Town, State, Zip Code)  licott City, Md21042
ore,	of Heal of Heal fitem		20a. Method of Disposition 20b. Place of Dispo		20c. Location - City or Town, State
im	Page ment tant: I		4 Donation 5 Other (Specify) Dulaney	Valley 1, 2012	
Ball	permit. Page 'Department o Important; If any injury or once.				wski Funeral Home,P.A Baltimore, Md.21222
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.		y arrest, Approximate Interval Between Onset and Death
	Phylician  Medical		Immediate Cause (Final disease or condition resulting in death)  Kidney Failur  Due to (or as a consequence of):	:e	Onset and Death
1	Examiner		Hypertension		
	n #	iner	Sequentially list conditions, if any, leading to immediate Dause. Enter Uniderlying		
	ecuter and al-trans	Examiner	Cause (Disease or injury that initiated events c Due to (or as a consequence of):		
0	nat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	lical	d		
876	tificate ng phy e as th	Med	IF FEMALE:		
Box 68760	ath cer attendi for use	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
). B	the dea	hysi	1   Yes 24 No 9   Unknown	other (speedify)	
P.O.	s that gned k	by	Part II. Other significant conditions contributing to death but not resulting in the u	, , ,	id tobacco use contribute to the cause of death?
rds	v requires that been signed should be det	eted			Yes 2 XNo 3 Probably 4 Unknown
Division of Vital Records,	sician: The law r certificate has b lirector, page 2 s	Completed		р	utopsy prior to completion of cause of death?
a B	an: Th tificat tor, pa	Be C	25. Was case referred to medical	26. Place of Death (Check only one)	′es XXXNo 1
Ζţ	hysici nis cer al direc	70 E	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatier	t 3 DOA Other: 4 Nursing Home 5 F	lesidence 6 🕅 Other (Specify)
ιof	Jing Pl	ate:	27. Manner of Death  1 Natural 5 Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury	28c. Injury at work?  M 1  Yes 2 No	be how injury occurred
Sio	or Attendi after death. Director: A I in by the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined determined	eet, factory, office 28f. Locatio	on (Street and Number or Rural Route Number,
Ω	ital or irs afte ral Dire		building, etc. (Specify)	City or	Town, State)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier  (Check 2 Medical Examiner: On the best of my knowledge, death of only one)  3 Certifying Nurse Practitioner: of the best of my knowledge,	igation, in my opinion, death occurred at the time, da	ate and place, and due to the cause(s) and manner stated.
	Viit Voir Con		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed huse of death (Item 23a) (Type, F		May 29, 2012
			Dr. Andrew Lazris, M.D. 6334 Cec	lar Lane #103,Colum	bia, Md. 21044
ł	Stat Registra	e ar	31. Date filed (Month, Day Year) 7 2012 32. Registrar's Signature	backet	
				The second secon	

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ isov Month 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death eriatric 8. Date of Birth (Month, Day, **Funeral**  Birthplace (State or Foreign Country) Director 1 🗆 M 2 🗙 F show 10a. State aţ 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No 10g. Citizen of What Country? Funeral USA 21040 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify. "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life\_DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me Secondary (0-12) Mental Hygiene. OOK Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bob Health ar. m 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dayahter Edgewood. 21040 Mn Important: If item 2 any injury or other tonce, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ó Burial 2 Cremation 3 Removal from State Aberdeen, Mississippi ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line NCER WITH METASTASIS Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last for use as the burial-train Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death be detached 9 Unknown To the Hospital or Attending Physician: The law requires that the Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗆 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Hilda Alverta Wright 2012 35p. Medical 06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Director 217-20-4087 1 □ M 2 🔀 F Yrs. 04 06 24 MD 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits treumetic event, the Medical Examiner must be notified 28a-f 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21207 3501 Howard Park Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. should be filed within 72 hours after and Mental Hygiene.

is marked other than "netural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 V Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
This bind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Howard Johnson (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hotal Maid grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Lottie Vanlandingham William Carter 1 and 2 should be Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Md 21213 3528 Chesterfield Ave, Baltimore, Denise Lee-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore National 6/12/2012 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 2 a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Sta disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and detached for use as the burlal-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day P.0. t by 1. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been sly irector, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific: completely filled in by the funeral director, of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural Division work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles of

State Registrar

31. Date filed (Month, Day, Year)

670

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peter Augburn 9:02 A M Ma 2012 Medical County of Death Prince George's 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Laurel Regional Hospital Laure If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Hours (Month, Day, Year) 7/16/1929 238-46-7181 Country) 82 Director 1 X M 2 □ F NC Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location the Maryland 10d. Inside City Limits **Funeral Director** notified MD Prince George's Riverdale 1 X Yes 2 No ъ 10e. Street and Number 10f. Zip Code items 23a or ner must be r 10g, Citizen of What Country? 5600 54th Ave. Apt. 505 20737 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ral", or iter Examiner Armed Forces ò 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Custodian 5th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mead Augburn Rose Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heath ar Important: If item 27 is any injury or other trau once. 5600 54th Ave. #505 Riverdale, MD 20737 Edna Doggett/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 5/25/2012 Scotland Neck, NC Mary Chapel Cem. 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licenses 22. Name and Address of Facility Briscoe-Tonic Funeral Home Emberly Clariscoe-Tonic 2294 Old Washington Rd.Waldorf, MD20601 23a. Part 1. Enter the titlease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Malignant Mesotheliomo disease or condition resulting in death) year Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury OF 05 3 FOUR HOUSENESS OF Pneumonia Exami the burial-transit The law requires that the death certificate be executed 3-4 Weeks and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atter in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending iniury after death Accident filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on and title of certifier 29b. Signatui TENSINE 005 7216 7300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dusen

Registrar

State

Baako

Michae

Regional

aurel

egistrar's Signature

Hospital

Laurel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death  $\overset{\text{Day}}{2} \underline{0} \underline{12}$ Physician/ Month Asmorom Berhe May 17,  $\mathbf{p}^{\mathsf{M}}$ 11:27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 577-11-7407 **Director** 1 ☑ M 2 □ F 34 Italy Usual Residence of Decedent 6, 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number ö 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 525 Thayer Ave., #220 20910 Eritrea permit. Page 1 and 2 should be filed within 72 hours after death begartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 A Never Married 2 Married ģ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Tesfaye Berhe Asefash Nirayo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asefash Nirayo/Mother 525 Thayer Ave., #220, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State May 21 2012 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licen 22. Name and Address of Facility Francis J. Coll 500 University ins Funeral Home Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani Ωε \_\_\_\_\_ Due t (or as a consequence of) disease or condition resulting in death) Medical Examiner phalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury Diabetes that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical hronic Kidne P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the at id be detached for Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 ₩No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performe death? certificate 2 1 No 1 Yes 2 No Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 400 Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deam.

To the Funeral Director: After this romnletely filled in by the funeral di 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18th 2012 226 bredi D68005 GM May

Registrar

DHMH 17 Rev 06-2011

State

Carnoll Avenue, Takona

Park , MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenniter Objectimo

21 2012

31. Date filed (Month, Day, Year)

7600

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year har les It. M. Beatty 17 аМ 12:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Potomac Valley Health & Wellness Ctr. Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours Director 411-56-6547 75 11 M 2 □ F Oct. 9, 1936 Tennessee sidence of Decede or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct Montgomery 1 ☐ Yes 2 🛣 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9706 Marshall Avenue 20901 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No unk Black, White, etc. ۾ 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", If Yes Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles H. M. Beatty Mary B. Dickey permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. M. Beatty, III/Son 20319 Beaconfield Terrace, #102, Germantown, MD 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1¾ Burial 2 ☐ Cremation 3 ☐ Removal from State May 24 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 2012 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenson Lei 500 University Blvd. W., Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death 4-5 yrs Physician Renal Cell Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): <sup>'</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). ng physician and a as the burla-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending property for use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| cate has been sig Completed 1 ☐ Yes 25tt No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🖺 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4XXNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 10 38 2 May 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, 9043 Shady Grove Court, Rockville, MD 20850 MD 31. Date filed (Month, Day 62. Registrar's Signature State

Registrar

21

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				tate of Marylar				-	_			
		-	State Registrar		Cer	tificate of	Death		Reg. No. 20	12 18041		
н	Physicia	n/	1. Decedent's Name (First, Middle, Last)					Date of Dea     Month	19 201	3. Time of Death		
-	Medic Examin	al	Grace Kelly  4a. Facility Name (if not institution, give street			4b. City. Town, o	or Location of Deat	May	4c. County of E			
the same of	Examin	CI.	523 Calvert Street				lestown		Cecil			
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days		(Month, Day	(Year)	Birthplace (State or Foreign Country)		
	-		213-44-8774 Usual Residence of Decedent	97_				Aug. /	, 1914  Ha	rlan,Kentucky		
	yland -f sho ed at	ctor	10a. State 10b. County	, 10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits 1   Yes 2 □ No		
	or 28a	Dire	Maryland Cecil  10e. Street and Number		Char	lestown 10f. Zip Code			10g. Citizen of What			
	with the s 23a ust be	Funeral Director	523 Calvert Street			2	1914		United	States		
	death r items		A A	Vas Decedent Ever in U. vmed Forces?	S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.		
920	s after ral", o	ed by	or Elyafia 4 □ Discussed If	Yes 2 X No Yes, Give Year or Dates.	Yes 2 💢 N	Specify:		Specify:	White			
2-0	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade control			dent's Usual Occu kind of work done	pation during most of wo	rking	16b. Kind of Business Industry			
121	ithin 7, ene. • than	Com		College (1-4 or 5+)		o NOT use retired omemaker	)		Own H	Iome		
_	filed within tal Hygiene. d other thar event, the M	Be	17. Father's Name (First, Middle, Last)		11,	JIII EIII AKEI	18. Mother's Na	me (First, Middle,		ione		
ylaı	Menta	욘	John H. Kelly					ida Creed				
Mar	2 shouth and the and the results in the traum		19a. Informant's Name/Relationship (Type, Pr Larry Barton, Sr. / S	rint) Son			and Number or Ri oad, E1k1		; City or Town, State 11and 219			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other pla	1 1/	7 Dagey ,	20c. Location - Cit	y or Town, State		
imo	Page ment c tant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Un	ion Ce	metery	20	012	Elkton, N			
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee						eral Home,	, P.A. Maryland 21901		
			23a. Part 1. Enter the disease, or complication	ons that caused the dea						Approximate		
Jane	Physician/		23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one out Immediate Causes (Final disease or condition resulting in death)	use on each line	Mary	Artery	Diseaso	_		Interval Between Onset and Death		
-	Medical Examiner		resulting in death)	Due to (or as a conseq	uence 🕳:	75.0		<del></del>		101.3.		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	juence of):	<del> </del>						
D	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c. —		, ,							
	be executed sician and burial-transit	cal Ex	resulting in death) Last	Due to (or as a conseq	juence of):							
	physic the bi		d									
9289	Physician: The law requires that the death certificate this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Physician/Medi	20b. Was decedent pregnant	f yes, outcome of pregna	ancy	Testania progna	201/		23d. Date o	f delivery		
Box	death he atte ed for	sicia	1 Ves 2 No 4	Pregnant at time of		Other (specify)			Month	Day Year		
Ö.	at the ed by t detach		Part II. Other significant conditions contribu	uting to death but not re	sulting in the	underlying cause o	iven in Part I.	23e. Did to	bacco use contribut	te to the cause of death?		
Division of Vital Records, P.O.	v requires that s been signed b should be deta	ed by						1 🗆 '	Yes 2 No 3	Probably 4 Unknown		
Sorc	law req has bee le 2 shou	Completed						24a. Was autop	osv prior	e autopsy findings available r to completion of cause of		
Re	The la	Con						perfo	rmed2 deat	th? Yes 2 No		
/ital	sician certifi irector	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	tal:	ER/Outpatio	Ot	Place of Death (Che	_	dence 6 🗆 Other (S	Canada)		
of/	Attending Physician: The law r death. ctor: After this certificate has by the funeral director, page 2	te: To	27. Manner of Death 2	8a. Date of injury (Month, Day, Year)	28b. Time o		ıry at		ow injury occurred	specify		
ion	tendir death. tor: Af the fur	Certificate:	2 Accident Investigation			M 1 [	Yes 2 No					
ivis	Jor At after of Direct		4 Homicide determined	8e. Place of Injury - At h building, etc. (Specit		eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: C							s stated. the cause(s) and manner stated		
	the H	Me		actioner: To the best of n		death occurred at		lace, and due to the		er as stated.		
	vit To		Sachder - S-	MD		200	23322	1	5. 28	2. 2012.		
	3		30. Name and address of person who comple S. S. Sachdev MD	eted cause of death (Iter	m 23a) (Type, l	Print) EE	23322 2kIm	MD 219.	2/.			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	acker						
	Registr	ar	MAY 2 2 2012	Commi	14. 19	80.0x -						

Examine Physician/Medical signed by the attending physician be detached for use as the burial <u>۾</u> Completed certificate has been sector, page 2 should director, Be Certification: Director: I in by the f

2

Medical

State

Registra

pur

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed

Due to (or as a consequence of): events resulting in death) Last **X** UNPENDED  $\square$  AMENDED 23a, 27, per me, g928 6-21-12 sm IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown

if any, leading to immediate

(Disease or injury that initiated

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Oue to (or as a consequence of)

25. Was case referred to medical Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

1 X Natural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide determined Homicide

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature CABLAR

2 Fetal death

5 Other (Specify)

3 Ectopic pregnancy

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

29d. Date signed (Month, Day, Year) May 23, 2012

28f. Location (Street and Number or Rural Route Number, City

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 ✔ Unknown

death?

1 🗸 Yes

Day

24b. Were autopsy findings available prior to completion of cause of

Year

2 No

Month

OCME

24a. Was an

Other Nursing Home 5 Residence 6 Other

autopsy performed?

Yes 2 No

28d. Describe how injury occurred

24 hours a Funeral

within .

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorothy Mae **Bradley** May 2012 1400 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Callaway St. Mary's . Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) Director 192-18-6054 1 M 2 🕱 F 87 12/24/1924 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 K No St. Mary's Mechanicsville Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 27910 Rectory Court 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in LLS 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. within 72 hours after ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Wildowed 4 Divorced Completed White 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Nursing Aide Medical and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, . I and 2 should be a sent of Health and Me arrant: If item 27 is ready injury or other # ပ William Prince Lawrence Morris Elsie Emma Shoup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Kimberly S. Gregory/ daughter 27910 Rectory Ct., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State June 2, 2012 Washington, PA Washington 4 Donation 5 Other (Specify) of Fumeral Service Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (out a consequence of) burial-trar Due to (or as a consequence of) resulting in death) Last physician Medical that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day Pregnant at time of death the 9 Unknown g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospice Hospital 2 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA House 4 Nursing Home 5 Residence 6X Other (Specify) After this . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No of the safter death.

E Funeral Director: Afterely filled in by the fulled in the fuller. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie D0022102 30. Name and adds ess of person who completed cause of death (Item 23a) (Type, Print) eme Mary L. Kramer, M.D. 37767 Market Drive, Charlotte Hall, MD 20622 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 7012 0830 Paul William Bowers AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9800 Bowling Drive Charlotte Hall Charles 7. Age (In yrs. last birthday) If Under **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Director 1 👿 M 2 🗆 F 225-58-2094 66 Usual Residence of Decede 11/30/1945 Virginia 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2X No Maryland Charlotte Hall Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9800 Bowling Drive 20622 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Southern States Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture and Mental Hygier is marked other t Manager Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Bowers Charlotte Kropp Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. Gloria J. Bowers / Wife 9800 Bowling Drive Charlotte Hall, MD 20622 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial 5/30/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, PA. M00817 Laufun 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter 🖬 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ON 62 37 346 HEBNY Medical Due to (or as a consequence of): **Examiner** moretil PNEUMONZE Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit requires that the death certificate be executed DO FAU DIOBER that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 8-2-13-FALLUR 1 money the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 L Yes 2 L 9 D Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy oage perform Yes 2 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 □ Yes 2 □ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10)eme

Box 68760

P.O.

Records,

Division of Vital

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

115 A LAGRANGE

25

APLATS

mo

20646

DHMH 17 Rev 06-2011

P148876

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Daniel Bruce		Registrar	partment of ertificate of		Re	eg. No. 201	2   805
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)			2. Date of Deat Month	Day Year	3. Time of Death 1120 hrs
Toulour Exam	IIICI	Daniel C. Bruce 4a. Facility Name (if not institution, give street and number)	41	b. City, Town, or Location of Death	May 22, 20	4c. County of Death	
		18800 Roxbury Road		Hagerstown		Washington	
Funeral Director		006-68-3477 <sub>1</sub> ⊠ <sub>M 2□F</sub> 52	s, last birthday) Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min		h(MM/DD/YYYY) 9. Bir 8 / 1 9 5 9 Foreig Co	
Any		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	ity, Town or Locatio	n			10d. Inside City Limits
A	F	MD Washington Ha	agerstov	√n			1 Yes 2 10 No
Aaryla 28a-f :	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?
with the Maryland us 23a or 28a-f sho pe notified at once,		18800 Roxbury Road		21746		United St	
ath wit	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black,
fter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 ,	Yes 2 No specify:		Specify: Whi	te
ours a	ed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's	s Usual Occupation (Give kind of state of working life. DO NOT use reti		16b. Kind of Business/I	ndustry
36 in 72 h	plet	Elementary/Secondary (0-12) College (1-4 or 5+)		ne Operator	100)	Manufact	uring
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-fahent, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last)	1	18.Mother's Name	(First, Middle, M	laiden Surname)	
21215 uld be file Mental H marked c event, ti	Be	Stanley Clark Bruce		Norma			
MD 21215-0036 d 2 should be filed within 7 th and Mental Bygiene. n 27 is marked other than numatic event, the <u>Medical</u>	٩	19a. Informant's Name/Relationship (Type, Print )		Address (Street and Number or I			Zip Code)
C 42 = 7			Place of Dispositi	ion (Name of cemetery	Date	20c. Location - City or	Town, State
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N important: If item 27 is o injury or other traumatic		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or othe iverdale	er placeCrematory	29/12	Riverdale	e, MD
Baltimo permit. Page Department of Important:	1 8	21. Si nature of Funeral Service Licensee	22. Na	me and Address of Facility Br	ackett	Funeral 1	Home
	11	23a. Part I. Enter the disease, or complications that caused the deat		Federal St.			≥ 04011 Approximate Interval
Physician Wedical		failure. List only one cause on each line.	In. Do not enter the	a mode or dyring, such as cardiac o	respiratory arre	st, snock, of fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence	of):			3	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence	of):				
	Examiner	Chiseasa or injury that inflicted	01).				
uted nd ransit	Exa	events resulting in death) Last  Due to (or as a consequence d.	of):				
50, te be executed nysician and burial - transit	edical	UNPENDED AMENDED					
Box 68760, c death certificate be the attending physic ed for use as the bur	J/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pre		I death 3 Ectopic pregna	nev	23d. Date of delivery Month	ay Year
lox 6876 eath certificate the attending phy for use as the l	iclar	past 12 months?	dooth -	I death   3	licy	I World	ay real
, Bo; the death y the att	Physiclan/M	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not	reculting in the up	darluing cause aixon in Bort !	23a Did tot	pacco use contribute to 1	he cause of death?
ires that the signed by	ğ	. at the cases organization containing to dealing at the	resulting in the disk	de lyllig cause giver liv Fait i.		2 ✓ No 3 Prob	
rds, requir been s	Completed	-			24a. Was a		opsy findings available ompletion of cause of
of Vital Records, g Physician: The law requir wher this certificate has been s neral director, page 2 should	E O				perform	ned? death?	_
tal Rec cian: The l certificate l ector, page	Be	25. Was case referred to medical examiner?		26.Place of Death (Check	only one)		
f Vit	2	1 Yes 2 No	ER/Outpatient			Residence 6 Other	Scene
on of nding Pl th. r: After e funeral	Ö	1 Natural 5 Pending FOUND: Dey, Year)	28b. Time of Inju	ury 28c. Injury at Work?  1 Yes 2 ✔ No	Subject hang	ow injury occurred ged self	
Division tal or Attendiurs after death.	ficat	2 Accident Investigation May 22, 2012 3 ✓ Suicide 6 Could not be 28e. Place of Injury - At it	1050 hrs home, farm, street,	factory, office building, etc.		treet and Number or Rur	al Route Number, City
Division oppital or Attent hours after death neeral Director:	Certification:	4 Homicide determined (Specify) Jail/Penal	<u> </u>		or Town, St 18800 Roxbury	ate) Road, Hagerstown,	MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination					
To the comp	Medical	and manner stated.  29b. Signature and title of certifier		29c. License number	umo, date a	29d. Date signed (Mon	
		Langh & north not non		O.C.M.E.		May 23, 2012	,
	ł	30. Name and add set person who completed caus of death (Iter	m 23a)				
1W-0		V1 91/43/64/00/00 32		W. Baltimore Street, Baltin	more, MD 21	223	
St Regist	ate rar	31. Date filed (Month PV), 199 2012 32. Legistrar's Signal	ture				

BOXENBAUM, HAROLD / SII8/2012 09:02 AM

			Please Type or Print in E					-		_	•		
		•	For State Of War yield		tificate of L		aria ivi		Reg. No		18054		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Da	Long	3. Time of Death		
	Medic	al	Harold George Boxenbaum  4a. Facility Name (if not institution, give street and number)		45 CH T			May 18		12	9:02 A <sup>M</sup>		
	Examin	er	Suburban Hospital		4b. City, Town, or Betheso		or Death			. County of Dea			
Ť	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Bir	thplace (State or Foreign		
	Director		Usual Residence of Decedent	Yrs.							nsylvania		
	f shoved	ctor		, Town or Loc							10d. Inside City Limits		
	or 28a- notifie	Director	Maryland Montgomery Non	rth Pot	10f. Zip Code			Т	1 ☐ Yes 2 🛣 No				
	permit. Fage 1 and 2 should be filed within 12 hours after death with the Maryland permit. Fage 1 and 2 should be filed within 12 hours after the 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	14621 Settlers Landing Way			0878		_	ted Sta	•			
1	death r items iner m		11. Marital Status  1 □ Never Married 2 ★ Married  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ★ No	5. 13. W	Vas Decedent of H Yes, specify Cuba	ispanic Orig an, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit			
3	s arrer ral", o Exami	ed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:					White		
	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	ation during most	of working	ng		(ind of Business			
7	iene. r than the M	Com	Elementary/Secondary (0-12)		O NOT use retired) aceutical		entis	it	1	ood and Drug lministration			
2	al Hygi d othe	Be c	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd					Surname)				
y	uld be d Ment narke natic e	To	Clifford Boxenbaum					luttenb					
Z .	12 shoulth and 27 is r		19a. Informant's Name/Relationship (Type, Print) Naning B. Sugeng (Spouse)	1	g Address (Street : 1 Settle:						p Code) MD 20878		
ָנֻ ב	of Hea of Hea fitem rothe		20a. Method of Disposition 20b. P	lace of Dispos	sition (Name of		D	ate	20c. L	ocation - City o	Town, State		
	t. Page tment tant: I ijury o			etrópo Cremato	natory or other place Litan ory	N	lay l	9,2012	A1e	xandria	, Virginia		
	permi Depar Impor any in once.		21. Signature of Funeral Service Licensee (M006)		Name and Addre	ss of Facility	y Dev	ol Fun	eral	. Home,	10 East yland 20877		
П			23a Part 1/Enter the disease, or complications that caused the death shall, or went failure. List only one cause on each line.								Approximate Interval Between		
P	hysician/		Immediate Cause (Final disease or condition	7100	ASTRIC	CA	NCI,	MA	-		Onset and Death		
<i>F</i> 1	Medical Examiner		resulting in death)  Due to (or as a consequ	ence of):									
		xaminer	Sequentially list conditions, if any ladding for as a consequence of the consequence of t	ence oil:				•					
popi loc	and		Cause (Disease or injury that initiated events c. Due to (or as a consequence of the cons	ence of:									
2	sician buria	ical E	d							l),			
	Notice to be a second of the funeral director, page 2 should be detached for use as the burial transit.  No ompletely filled in by the funeral director, page 2 should be detached for use as the burial transit.	Physician/Medical	IF FEMALE:							- 11			
	attendii for use	cian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta	I death 3 🗌	Ectopic pregnand Other (specify)	су				23d. Date of de Month	elivery Day Year		
<b>i</b>	by the a	hysid	1   Yes 2   No 4   Pregnant at time of 6 9   Unknown	Jean J	Other (specify) _								
, thu	gned b	by P	Part II. Other significant conditions contributing to death but not resi	-	nderlying cause gi	ven in Part I					o the cause of death?		
	seen si	eted	BOWEL PERFORMATION					1 -			Probably 4 Unknown		
בי בי ט	e law r	Completed	273/3					24a. Was auto perfe	psy	prior to death?	utopsy findings available completion of cause of		
ב קיי	rtificat	Be Co	25. Was case referred to medical examiner?		26. Pl	lace of Deat	th (Check	1 \(\simeg\) Yes only one)	2 N	lo 1 ∐ Ye	s 2 🗆 No		
huojo	this ce al direc	임	1 Yes 2 No Hospital: 1 Mpatient 2			4				6 ☐ Other (Spe	cify)		
	th. After	cate	27. Manner of Death  1 Natural 5 Pending 20 Accident Investigation	28b. Time of injury	28c. Injur work M 1	yat ⟨?  Yes 2 □		8d. Describe	how injur	ry occurred			
2012	er dea rector by the	Certificate	3   Suicide 6   Could not be 4   Homicide determined building, etc. (Specify					28f. Location ( City or To			ıral Route Number,		
בֿ בֿ	ours aft eral Di filled in												
7	e nos 24 ho e Fune eletely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowl (Check only one) 3 Certifying Nurse Practitioner: To the best of m	and/or invest	igation, in my opinie	on, death oc	curred at	the time, date	and place	e, and due to the	cause(s) and manner state		
F.	Withii Voicemp		29b. Signature and title of certifier	, ,	29c. Licens	e number	,		29d. Da	ate signed (Mon	h, Day, Year)		
	20		Willing Frigon		0233	08			M	AY 18,	2012		
			30. Name and address of person who completed cause of death (Item VICTOR M. PRIEGO, MP (1420)	23a) (Type, P	rint) 506E DA	. RF	THE	SOA A	102	0817			
	Stat		31. Date filed (Month, Day, Year) 22. Registrar's Signet	ure for	w		, , , , , ,	/ /*					
) LIV	Registra H 17 Rev 06-2		MAI AN CUIL Jenus B.	7							<del></del>		
- # 11VI	nev 00-2	-011											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Month Day Collis Brake, Sr. May 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homewood of Williamsport Williamsport Washington If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. Director 417-28-3918 1 M 2 D F 12/10/1916 95 Alabama ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Washington Williamsport 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Avenue 21795 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black. White, etc. ρ 1 Never Married 2 Married Yes Yes, Give 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Correctional Officer Corrections and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alton Brake Lizzy Barnecastle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Sylvia Brake 712 Oak Forrest Ave., Catonsville, MD 21722 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Important: If its any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Rest Haven Cemetery 5/26/2012 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ONGESTIVE disease or condition m=~7HS Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 C Ectopic pregnancy 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes Completed HIPENTENSION. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DHEASE; CONONAMY 24a. Was an autopsy DEBILITY 2 No 1 Yes 25. Was case referre to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number D0051395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742

State Registrar

S

H

1110 MEDICAL

E.K. YSTERMO.

CAMPUS ROAD, SUITE

	AMEND	244	,25,28B,	Please PER MD G9	Type or Pri 29, 7/5/12 State of M	<b>nt in</b> TRT- arylan	Black I AME Id / Dep	ndelib partmer	ole In PER nt of H	FH G	ure A)	I/Copie ental Hy	s Ar	<b>e Legi</b> e	ble.	
			1 - State Registrar			,		ertificat				,	Reg. N	20	12	18056
	Physic	cian/	1. Decedent's Nam	1. Decedent's Name (First, Middle, Last)									eath D		Year	3. Time of Death
	Me Exan	dical	4a. Facility Name (ii	1005	e street and number)			4b. City	, Town, or	Location (	of Death		4	c. County o	f Death	3-00 P M
No.	Harford Memorial Hospital									le Gr				Harfo		
	Funer Directo	or	5. Social Security N	93/3	Sex 7. Ag	e (In yrs. I	ast birthday)	Months		If Under Hours	Min.	8. Date of Bi Jan 2	rth 3 <sup>y,</sup> 19	17		place (State or Foreign adelphia, P.
٤.	aryland a-f show fied at	fied at		10b. County Cecil		10c. Cit Ris	10c. City, Town or Location Rising Sun						-	1	0d. Inside City Limits 1 ☐ Yes 2 🄀 No	
00 P.M.	the Ma a or 28 be noti	Funeral Director	10e. Street and Nur	mber					ip Code				_	itizen of W	hat Cour	ntry?
0	th with ms 23 must	ner	234 Ba	rd Camero		21911								USA		
€. OC 215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1  Never Mari 3  Widowed	ried 2  Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates.	Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Find The Yes 2 No Specify:					ecify Yes or No- b Rican, etc.) 14. Race - An Black, Wh Specify:				•	
(J) 25	72 hou 1 "natu Iedica	nolet	. (Spe	15. Decedent's lecify only highest g			(Give	edent's Usu e kind of wo DO NOT us	ork done d	ation during mos	t of workin	g	16b.	Kind of Bus	siness Ind	dustry
212	within giene. er tha	ပိ		onday (0-12)	College (1-4 or	5+)		stmen		ficer	•			Bank	ing	
pu	filed tal Hyged oth other	To Be								18. Moth		(First, Middle			± a 1	
Maryland	uld be d Men marke	-	Louis  19a. Informant's N	C. Hartma			T					nel A.				
\ ∑	d 2 shoalth an 27 is		1	L. Bush	(daughte:	r)						Route Numb Risi:				
//////////////////////////////////////	e 1 and of Hei If item or othe		20a. Method of Dis	position	Removal from State	20b. F	Place of Disp cemetery, cre	oosition (Na ematory or	me of other plac	re)	Da	ate		Location - 0	•	
Ę (	it. Pag rtment rtant: njury o		4 Donation	5 Other (Spec		Ho	ckess						_			DE 19707
Bal	perm Depa Impo any il	ouce	21 Signature of Fu	TENL	C	CO283	, ,					andler Wilmi				
0			23a. Part 1. Enter shock, or hea	the disease, or con	nplications that cause one cause on each lin	d the deat										Approximate Interval Between
	Physicial Medic		Immediate Cause disease or condition resulting in death)	(Final	. a	YUCAV	deal	la	Goot	m					- 1	Onset and Death
lecy	Examin	_			Due to (or as	a consequ	uence of):									
0	F #	iner	Sequentially list co if any, leading to in cause. Enter under	riying	b. Due to (or as	a consequ	uence of):									
50	executed an and rial-transit	Examine	Cause (Disease or that initiated event resulting in death)	is a	c. Due to (or as	a conseq	uence of):									
34ch 9	cate be ex physician the burial	11=			d											
. Box 68	Attending Physician: The law requires that the death certificate be r death.  sctor. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2 9 Unknown	menths? No		th 2  Fetal death 3  Ectopic pregnancy at at time of death 5  Other (specify)							23d. Date of delivery Month Day Year			
, P.O	es that to signed by I be deta	≦	Part II. Other signi	ficant conditions	contributing to death t	out not res	sulting in the	underlying	cause giv	ven in Part	l.					ne cause of death?
He ecords	v requii s been should	Completed										24a. Was	s an	24b. W	ere auto	psy findings available
Rec	sician: The law of certificate has kirector, page 2 s	m o										perf	opsy formed? 2 <b>X</b> I		eath?	mpletion of cause of 2 \square No
Vita	cian: ertifica ector,	Be	25. Was case referr examiner?	red to medical	Hospital:						ath (Check	only one)				
~	Physic this c	은	1 Yes 2	X No	1 ☐ Inpat		ER/Outpati		Othe 28c. Injun	4 LI N		ne 5 Res				2
on/of	nding ath. r; After ie fune	icate	1 Natural 2 Accident	5 Pending Investigation	(Month, Da	y, Year)	injury		work			ou. Describe	HOW HIJE	ary occurred		
(127) Division	28d. Describe how injury occurred work?  28d. Describe how injury occurred work?									or Rural	Route Number,					
0	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2	Medical Exam	ysician: To the best of niner: On the basis of	examinatio	n and/or inve	estigation, in	n my opinio	on, death o	courred at t	he time, date	and place	ce, and due	to the car	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and		1	_			c. License	number	4			ate signed		
				had /	Indone		00 : =		DOC	065	991		W	lang	11,	2012
	10		30. Name and addr	1 /-	completed cause of c	ieath (Iten	n 23a) (Type,	, Print)						U		
	S Regis	tate trar	31. Date filed (Moni		32. Registr	ar's Signa	ture	park	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 2220 PM Michael A. Christopher Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SK150111 HICOMICO REGIONAL MEDICAL TENINSULA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 225-98-7635
Usual Residence of Decedent 1 🗙 M 2 🗆 F 47 2-13-1965 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Yes 2X No Fruitland MD Wicomico 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be r Funeral 305 Pine Street, Apt A 21826 items death 12. Was Decedent Ever in U.S. Armed Forces? 1 9 8 3 - 8 6 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc or. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The 127 is marked other than "natural", or any or other traumatic event, the Medical Examilury or other traumatic event, the Medical Examilury. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Army 1 ☐ Yes 2 XNo Specify: SpecifBlack 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cadista Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard 12 Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarice White Karl A. Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 803 Cornish Street, Salisbury, MD 21801 Tyler Christopher/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Veteran's Cem 5-29-2012 Hurlock, MD Donation 5 Other (Specify) ennie and Address of Facility 17 W. Isabella St. . Signature de l'eral Service Licensee Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ End stage Renal Dicease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertansian Sequentially list conditions, cause. Enter Underlying Examiner Chra to (or Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of). Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Hospital or Attending Physician: The law requires that the v. 4 hours after death. Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 performed: After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) Hospital မ 1 ☐ Yes 2 🗷 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred

Box 68760 P.O. Records, **Division of Vital** 

VA

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVISION ST LAZA HEZAL 31. Date filed (Month, Day, Year)

MAY 2 2 2012

Tu

5 Pending

Investigation

determined

6 Could not be

☐ Accident

3 Suicide 4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifie

egistrar's Signatur

SuiTEB SALISBURY, MD 21804

D68222

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 06-2011

injury

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nume Fractificant: Let a best of my included and become distribution, death and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	ate of Marylan				Mental Hy	giene	12 18058		
		Registrar  1. Decedent's Name (First, Middle, Last)	-	Cer	tificate of E	<i>Death</i>	2. Date of De	Reg. No. 🚄 U	1 - 1 - 1		
Physicia			d Clark In				Month May	_	3. Time of Death 2012 11:35 AM		
Medic Examin		Frederick Fore 4a. Facility Name (if not institution, give street		•	4b. City, Town, or	Location of Dea		4c. County			
LXUIIII		Blue Point Nursing I	Home		Baltin				Baltimore		
Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. la	ist birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 7, Yea <i>r</i> ) 7, 1931	9. Birthplace (State or Foreign Country) Maryland		
Director	1	Usual Residence of Decedent	80	113.			Sept.	7, 1931	Maryland		
land shov	ģ	10a. State 10b. County	10c. City	, Town or Loc					10d. Inside City Limits		
Mary 28a-1 otifie	Director	Maryland Cecil		Nor	th East				1 X Yes 2 □ No		
th the 3a or t be n	를	10e. Street and Number			10f. Zip Code	<b>1</b>		10g. Citizen of What Country?  United States			
ath wi	Funeral	14 Old Mill Lane  11. Marital Status 12. W	as Decedent Ever in U.S	S. 113. V	2190 Vas Decedent of Hi		Specify Yes or No-		e - American Indian,		
<b>Baltimore, Maryland 21215-0036</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married	rmed Forces? XXYes 2□ No Yes, Give Marine ear or Dates.	1 1	Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)		k, White, etc.		
5-0 2 hour "natu	plet	15. Decedent's Education (Specify only highest grade control		16a. Decedent's Usual Occupation (Give kind of work done during most of workin				16b. Kind of Bu	usiness Industry		
thin 7	Completed		ollege (1-4 or 5+)	life. DO	NOT use retired) ck Welder	J	3	Manufacturing			
Hygie Other ent, t	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Surname	9)		
/lan d be fi dental nrked tic ev	2	Frederick Ford Clar	k, Sr.			Mary	Elizabe	th Croth	ners		
Maryland 21215-0036 12 should be filed within 72 hours after tith and Mental Hygiene. 727 is marked other than "natural", o		19a. Informant's Name/Relationship (Type, Pr Michael A. Clark / S	,		g Address (Street a Manchest						
Saltimore, cernit. Page 1 and Department of Hes Important: If item any injury or othe		20a. Method of Disposition  1		lace of Dispo emetery, cren	sition (Name of natory or other plac	e) Max	Date		City or Town, State		
tim tr. Pag rtmen rtant: njury		4 Donation 5 Other (Specify)	Ma		e Cremato	,	312 <sup>4</sup> ,		, Delaware		
Depariment of the policy of th		21. Signal te of turnical Service a icens			Name and Address 7 South 1						
Medical Examiner purish transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the d. with. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each link.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
DIVISION Of VITAI RECORDS, F.O. BOX 68 / 60 W To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	yes, outcome of pregnar ☐ Live Birth 2 ☐ Feta ☐ Pregnant at time of d ☐ Unknown	y		23d. Dat	te of delivery nth Day Year				
IS, P.O.  Lires that the signed by all the deta	by	Part II. Other significant conditions contribu		ibute to the cause of death?  3  Probably 4  Unknown							
Kecords, The law requires rate has been sig page 2 should b	Completed						24a. Was auto perfo	psy prmed?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
VITAI I	Be	25. Was case referred to medical examiner?				ace of Death (Cr					
T VI Physic this c	은	1 ☐ Yes 2 No Hospit	1 Inpatient 2 I	ER/Outpatien		4(LZ) Nursing	Home 5 Resi				
n of ding Pt th. After th funeral	gate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work M 1 🗆	yaı ? Yes 2 □ No	28d. Describe	now injury occurre	ed		
DIVISION tal or Attendir s after death. al Director. After in by the fu	Certificate:	2 Cuiloido 6 Could not be	le. Place of Injury - At ho building, etc. (Specify)	me, farm, stre			28f. Location (S City or Tov		er or Rural Route Number,		
E Hospita 124 hours 5 Funeral leted fillec	fedical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: Oonly one) 3 Certifying Nurse Pra	n the basis of examination	and/or invest	igation, in my opinic	on, death occurre	d at the time, date a	and place, and due	e to the cause(s) and manner stated.		
To the within To the comp	Σ	29b. Signature and title of certifier			29c. License			,	(Month, Day, Year)		
		TAN XINEMIT			2004	50T)	,	5/10/	2012		
2+IVA		30. Name and address of person who comple	7MD 693	4-AV	ATION	BUDE	SUITEN-	-l Glo	NENLE, MD ZIGH		
Sta Registra		31. Date filed (Month, Day, Year)  MAY 1 4 201	32. Registrar's Signat	ure .	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201<sup>Year</sup> Physician/ Charlotte Lee Caputo May 14 1825 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 216-56-6702 **Director** 1 □ M 2 👫 F 60 Aug. 18,1951 Maryland Usual Residence of Deced 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director or 28a-f 1 ¥ Yes 2 □ No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 2205 Cedar Lane 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: U.S.A. Specify: 3 Widowed 4 Divorced Completed and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) V.A. Medical Center College (1-4 or 5+) Elementary/Secondary (0-12) Certified Nursing Assistant Perry Point, Maryland Four Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Edgar Burton Violet Irene Riale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Albert J. Caputo (Husband) 50 Moyer Drive, Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State West Chester, R.A. Ferris & Co., Inc. 05/16/12 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service License <sup>22</sup> Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ circulatory Acute disease or condition resulting in death) Medical **Examiner** multiorgan Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 m800379966 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown Urosepsis 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' hours after death. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 7 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely f (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Jul Wom When 29d. Date signed (Month, Day, Year) D 63420 May 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Dr Bel Air MD 21014. Khara 31. Date filed (Month, Day, 32. Registrar's Signature State MAY 18

Registrar

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital

21215-0036

Maryland

Baltimore,

Medical 2 Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D24093 May 17, 2012 oleted cause of death (Item 23a) (Type, Print)
3110 Gracefield Road Silver Spring, Maryland Mark Parkhurst, MD 31. Date filed (Month, Day, Year) MAY 2 1 2012 State Registrar A. park DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Allan McConnell Craig, III 19 9:35 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7016 Channel Village Court, Apt. T-1 Anne Arundel Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 31, 1934 **Funeral** 5. Social Security Numbe 100–28–5833 9. Birthplace (State or Foreign Min 77 New York **Director** 1**XX**M 2 □ F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2XXNo 10e. Street and Number 10g. Citizen of What Country? U.S.A. 7016 Channel Village Court, Apt. T-1 21403 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ö \$ 1 Never Married 2XX Married 1XXYes 2 □ No
If Yes, Give
Year or Dates. 1953–59 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXNo Specify: "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Sales Executive Printing Paper Industry Be 18. Mother's Name (First, Middle, Maiden Surname)
Carolyn Wickes 17. Father's Name (First, Middle, Last) Allan M. Craig, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21403Carol Craig/wife 7016 Channel Village Court, Apt. T-1 Annapolis, MD permit. Page 1 and 2 Department of Healt Important: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State any injury or 5/22/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of uneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Small Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) om on This Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Physician: The law requires that the death certificate be executed Cause (Disease or injury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 sign. Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) 1 Yes Other: 2 မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27...Manner of Death To the Hospital or Attending Pleating 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 2 Accident 3 Suicide 5 Pending injury Division 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) DS2830 may Canne 21,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO3 Medical Parkway #210 State Registrar

Joseph Daniel Cole 12-03980

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 18062 State of Maryland / Department of Health and Mental Hygiene UNK UNK 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day May 25, 2012 2053 hrs **Medical Examiner** Joseph Daniel Cole 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death St. Marv's 12595 Coffee Hill Road Chaptico If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** oreian Months Days Hours Country) Maryland Director 1X M 2 F Yrs 08-27-1941 70 217-44-4571 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 28a-f short more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Maryland St. Mary's Chaptico 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 12595 Coffee Hill Road 20621 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 V Never Married Yes Specify: Black 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Mechanical 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice C. Campbell James D. Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennette Thomas/Niece 409 Patuxent Court La Plata, Maryland 20646 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State rtant: 05-29-2012 Charlotte Hall, MD 4 Donation 5 Other Specify. Brinsfied-Echols 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A 21. Signature of Funeral Service Licensee M00945 211 St. Mary's Ave. La Plata, Maryland 20646 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease with Approximate Interval Physician Between Onset and (Medical Death a occlusive thrombus of right coronary artery Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of). if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, per me, g928 6-8-12 sm UNPENDED After this certificate has been signed by the attending physician in the and director, page 2 should be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year 1 Live birth 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other | Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director:
completely filled in by the fi Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) May 26, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD. 31. Date filed (Month, 1

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

32. Registrar's Signature

3. Time of Death

6:28 A

10d. Inside City Limits

1 Yes 2 K No

9. Birthplace (State or Foreign Country)

Approximate Interval Between Onset and Death

 $20\overset{\text{Year}}{12}$ 

14. Race - American Indian, Black, White, etc.

White

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Crabbs May Medical Raymond 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mt. Airy If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. 01/10/1928 216-22-1899 Yrs Director 84 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director MDFrederick Frederick ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 8515 Rocky Springs Rd. 21702 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1946-48 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Frederick Brick Works General Manager or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ည Charles Crabbs Clara Boyer 19a. Informant's Name/Relationship (Type, Print) Department of Health are Important: If item 27 is any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marty Crabbs/son 8003 Dustin Dr., Frederick, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Olivet 05/22/2012 4 Donation 5 Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, p.A. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ (Slase disease or condition Medical resulting in death) consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Hospital or Attending Physician: The law requires that the death Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence ပ 1 Inpatient 2 ER/Outpatient 3 DOA 6 X Other (Sper Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation n, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death ccurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certific 29d. Date signed (Month, Day, Year) au

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Robert Kauffman,

. Date filed (Month, Day, Year)

300 W

32. Registrar's Signature

record

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

PIER

Year

UX

State Registrar

ank

Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ma Physician/ 340 William Charles Chatkin 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min Days Director 218-24-7788 1**XX**M 2 □ F 80 02/25/1932 Maryland Usual Residence of Decedent 0a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 🗌 Yes 2 ី No Maryland Washington Hagerstown o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 18739 Rolling Road 21742 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) the Ith and Mental Hygien 27 is marked other the r traumatic event, the 5+ Pharmacist Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert H. Chatkin Evelyn L. Lyon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other tra Dorothea Chatkin / Wife 18739 Rolling Road Hagerstown, Maryland 21742 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 05/25/2012 | Hagerstown Maryland Significant Sep Co Li 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician muil disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tran Due to (or as a consequence of): burialphysician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year should be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ mith 1 Yes 2 No 3 Probably 4 Unknown Completed peen eedu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 21X No 24 hours after death.

Funeral Director: After this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Tes 2 X No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

Date filed (Month

Northern Au Hagenton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hmood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05716/2012 EVERETT AMBROSE CURTIS, JR. 9:10 P М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hyattsville CHI Group Home Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** X M 2 □ F Days Months Hours Min. 52 219-88-9571 Director 08/18/1959 Usual Residence of Decedent or 28a-f show notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Hyattsville 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō rmust be r Funeral 10200 Riggs Road 20783 USA items 2 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces? Black, White, etc. þ Never Married 2 Married Báltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. Completed Back. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A h and Mental Hygien 7 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Everett A. Curtis, Sr. Theresa Jennings 127 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troone. Joyce Middleton/sister 12215 Quintette Lane, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 5/24/2012 Veterans Cem. Cheltenham, MD Signature of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home Dunge 246 N. Washington St. Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician) Marginal Cell Lymphoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): law requires that the death certificate be executed sician and buria Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No cate has page 2 s Hospital or Attending Physician: The certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation 24 hours af er dead Funeral Director: ☐ Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 039550 5-17-12 1D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George C. Hajjar, Jr., M.D., 4850 Forbes Blvd., Lanham, MD 20706

State

Registrar

31. Date filed (Month, Day, Year,

MAY 22 2012

37. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vlae zaheth 01:104 Mai 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Caltimore 111670UU2 HOPKINS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 228-56-4772 68 Director 1 □ M 2 🖾 F March 3, 1944 Virginia rel", or items 23e or 28e-f show Examiner must be notified at 10a, State 10b. County within 72 hours efter death with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director Virginia 1 X Yes 2 ☐ No Culpeper Culpeper 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 22701 329 West Fairview Road, Lot #3 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ξ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ▼ No Specify: Completed 3 ☐ Widowed 4 ☑ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Heelth end Mentel Hyglene. Importent: If Item 27 is marked other then eny Injury or other treumetic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Correctional Center 12 Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lucy E. Riley Bland F. Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1225 Mort Colvin Lane, Amissville, VA 20106 Sandra L. Chamberlin, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Amissyille Baptist Church Cemetery 1 € Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/4/2012 Amissville, VA Moser Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 233 Broadview Ave., Warrenton, VA an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Diffuse Physician, B Medical resulting in death) Due to (or as a co de uence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exam or Attending Physicien: The law requires thet the deeth certificate be executed Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 8e 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospitel c thin 24 hours of the Funeral Di Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 1 @Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number M.P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pahl Kaustubha MD Street Calternore, 40 21287 1800 Deleans

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 8:40 am Mary Virginia Daisey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MICOMI HOSDICO CIT If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 1/1/1942 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Country Director 70 42 0419 1 🗆 M 2 🗓 F PA th and Mental Hygiene. 27 is merked other then "neturel", or iteme 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 28430 Old Quantico Rd. 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pege 1 and 2 should be filed within ment of Heelth and Mental Hyglene. ent: if item 27 is merked other ther Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 8 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Mildred Evans John Thomas Evans, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felicia Ann Birch (daughter) 6598 Benita Ave. Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Pege 1
Depertment of Importent: If it any injury or or once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 5/23/2012 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) Sunset Mem. Park 22. Name and Address of Facility The Burbage Funeral al Service Lices 108 William St. Berlin, MD 21811 Approximate Interval Between Onset and Death c, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of ettending physicien end i for use es the burial-trensit To the Hospitel or Attanding Physician: The lew requires that the deeth cartificate be executed within 24 hours effer deeth.

To the Funeral Director: After this cartificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burisi-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 ∐**vx**lo |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 6513 ss of person who completed cause of death (Item 23a) (Type, Print) TERN SHORE DE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2012 John Robert Dunworth, Jr. 9:42 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's 6. Sex 1 M 2 D F . Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 05/27/1941 Baltimore, MD 70 Yrs **Director** 212-36-9174 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? Funeral with USA 11702 Green Springs Avenue 21093 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 Black, White, etc. 1 Never Married 2 Married 9 1 Yes 2 No Specify Maryland 21215-0036 White If Yes. Give Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self-Employed Real Estate Broker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Robert Dunworth, Sr. Rose Heinlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 11702 Green Springs Ave., Lutherville, MD 21093 LeSales Dunworth / Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem 05/25/2012 | Charlotte Hall, MD . Sign true of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Echolo. #M00817 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner BRAL Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No n signed by the a ld be detached f 9 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 2 🗌 No thin 24 hours after death.

the Funeral Director, Aimpleted filled in by the fu death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2 To the F ITIVA pro

ပ္

Stephen P. Cafferty, State Registrar

(Check

only one 29b. Signature

30. Name and addre

22333 Greenview Pkwy, Unit 5 A, Great Mills, MD 20634 gistrar's Sign

of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 10:35 P M Year George Degerberg Jr. Nelson 05/14/2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Chevy Chase 5100 Dorset Ave If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 001-12-0137 92 1X M 2 | F Pennsylvania 5/17/1919 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Chevy Chase 1X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States 5100 Dorset Avenue Apt. 202 12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No World

If Yes, Give War I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 X Widowed 4 Divorced War II Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Games Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname George Nelson Degerberg Katherine Hunsicker 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Degerberg / Son 3855 Oak Street Cincinnati. Ohio 45227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State Old Hopkinton Cemet. Old Hopkinton, NH 4 ☐ Donation 5 ☐ Other (Specify) 5/24/12 Signate of Funeral Service Dicer 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Recurrent Pneumonia - Hemoptysis 1 Year Sequentially list conditions 3d. Date of delivery Month e contribute to the cause of death? No 3 Probably 4 Unknown

Physician Medical Examiner

Physician/

Medical

Director

Funeral

þ

Completed

Be

2

Examiner

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at

Baltimore, Maryland 21215-0036

and as the burialthe attending physician use signed by pe peen page 2 After this certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page

requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Examine by Physician/Medical Completed Be ပ

Certificate:

Medical

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
Part II. Other significant conditional Congestive Hea	ns contributing to death but not resulting in the underlying cause given in Part I.  TERMINE	1 🗆 Yes 2	use contribute to the cause of death?
		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of

25. Was case referred to medical examiner?
1 ☐ Yes 2 🔀 No 27. Manner of Death 1 X Natural

Accident

Suicide

5 Pendina Investigation 6 Could not be 4 Homicide determined

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

D23783

Other: 4 Nursing Home 5 X Residence 6 Other 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 15, 2012

death? 1 Yes 2 No

Building Hall

performed? Yes 2 X N

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature an 29c. License numbe 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel J. Esposito MD 5530 Wisconsin Avenue Suite 1400 Chevy Chase, MD 20815

State Registrar

20

31. Date filed (Month, Day, Year)

MAY 22 2012

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Ethel Marie Eastburn MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CWISTA MEDICAL PLATA CHAPLES CENTER Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min. **Director** 578-34-5314 1 🗆 M 2 💢 F 84 Maryland 04-15-1928 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 X No Bryans Road Marvland | Charles 10f. Zip Code 10g. Citizen of What Country? ō 10e Street and Numbe , or items 23a Funeral 7273 Carroll Drive 20616 Charles 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Housing e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John A. Purdy Mary E. Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Robert G. Eastburn/Husband 7273 Carroll Drive Bryans Road, Maryland 20616 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 🗷 Burial 2 💢 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem. 5/21/12 Charlotte, Hald, MD 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. 21. Signature of Funeral Service Licensee St. Mary's Ave. La Plata, Maryland 20646 M00945 211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami the burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ped Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death? 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) To Be Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t iniury Natural 5 Pending work?

1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation Suicide Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurge Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18 12 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. TCHD, 5/17/2012, TAJ State of Maryland / Department of Health and Mental Hygiene Amended 19b, 1- State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ MAY 15 CHARLES ALTON EWING, SR.  $P^{M}$ Medical 11:25 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11766 CORDOVA ROAD CORDOVA TALBOT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 218-34-8915 1 X M 2 🗆 F 95 11/5/1916 MARYLAND Usual Residence of Decedent 28a-f show 10h Counts must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits MD TALBOT **CORDOVA** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11766 CORDOVA ROAD 21625 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No "natural", or iterredical Examiner of 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 SELF-EMPLOYED SCRAP DEALER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ pe FRANK EWING MARIE TYLER ge 1 and 2 should be nt of Health and Mer If item 27 is marke 19b. Mailing Address (Street and Nur**RoO & R**ural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DONNA E. ROBINSON, DAUGHTER 8903 TEAL POINT DRIVE, EASTON, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PK 5/21/2012 EASTON, MARYLAND Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Betwee Immediate Cause (Final Physician/ disease or condition day Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, The law requires 1 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes of Vital To the Hospital or Attending Physician: 25. Was case refer ed to medical æ examiner? Other: 4 Nursing Home 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Division ithin 24 hours after death.

the Funeral Director: Af

ompletely filled in by the fu 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

TAJ 9

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one

29d. Date signed (Month, Day, Year)

21601

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of M	1arylan	d / Depa	artment	of He	ealth a	and M	iental Hyg	jiene _		100	770
	61		State     Registrar			Cer	tificate	of De	eath		F	Reg. No. 20	12	180	172
	Physicia Medic		Decedent's Name (First, Midd     James	le, Last)			Emer	son			2. Date of Dea May 16		Year	3. Time of E 6:30	Death A M
	Examin		4a. Facility Name (if not institutio				4b. City, Town, or Location of Death					4c. County of Death			
	1		Manor Care Che						hase				gomer	У	
	Funeral Director		5. Social Security Number 508-20-1657 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. Ia 85	ast birthday) Yrs.	If Under 1 Months		If Under 2 Hours		8. Date of Birth (Month, Day June 9,	Birth 9. Birthplace (State or Foreign Country) Oregon			
	and show	ᇹ	10a. State 10b. Count	у	10c. City	y, Town or Loc	ation						1	0d. Inside City	/ Limits
	Maryla 18a-f	Director	MD Mont	tgomery		Bet	thesda							1 🗆 Yes	2X No
	a or 2		10e. Street and Number										Citizen of What Country?		
	h with	Funeral	6311 Tulsa					2081				United	Stat	es	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu		d If Yes, Give Year or Dates. ent's Education nest grade completed)	es? 2 \( \text{No WW II} \) If Yes, spe 1 \( \text{Yes} \)			No Occupat	Specify:	, Puerto I	cify Yes or No-Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White  16b. Kind of Business/Industry			
72	ithin iene. r thar	Con	Elementary/Secondary (0-12)	College (1-4 or <b>5+</b>	5+)		O NOT user CIA	etirea)				Federa	1 Gov	ernmen	t
and 2	be filed w ental Hygi ked other c event, 1	To Be	17. Father's Name (First, Middle, Clarence Will:	Last)			0111	1			(First, Middle, I Brown				
Maryland	2 should Ith and Me 27 is mark r traumati		19a. Informant's Name/Relation: Noreen C. Emer	ship (Type, Print)	)				nd Number	r or Rura	Route Number,		State, Zip (	Code)	
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 1 □ Donation 5 □ Other	n 3 ☐ Removal from Stat	e Ce	lace of Disponentery, cremetery, cremetery	natory or oth	er place)	y	May 2012	)ate	20c. Location	•		
alti.	mit. Poartm sortar sortar / injur		21. Signature of Funeral Set 12 Lipinsee 22. Name and Address of Facility									German			
m	Depar Impor any in		1 RACY ATE	we	MOTIT	/ D	eVol 1	Fune	ral F Gai	lome ithe	, 10 Eas	MD 208	Park 77	Drive	,
ai	Physician/		23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition	or complications that cause only one cause on each lin	ne.	n. Do not ente	r the mode				_			Approximate Interval Betw Onset and De	een
The same of the sa	Medical Examiner		resulting in death)	Due to (or as	a consequ		1124								
	- EA	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dvspha Due to (or as		ience of):									
	cate be executed physician and the burial-transit	xam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
_	be exe	dical E	resulting in death) Last	Due to (or as	a consequ	lence on.									
760	phys phys the	i w i		d											
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transicompletely filled in by the funeral director, page 2 should be detached for use as the burial-transic	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?										23d. Date of delivery Month Day Year		
, P.O.	es that the	by Ph	Part II. Other significant condit			_		use give	n in Part I.			pacco use cont			
rds	equir seen s should	etec										es 2 No			
Reco	The law rate has the page 2 s	Completed									24a. Was a autop: perfor 1 🗌 Yes	med?		osy findings av mpletion of car 2  No	
ta	ician: certific ector,	Be	25. Was case referred to medica examiner?	Hospital:					e of Deat	h (Check	only one)	71			
Ž	Physi this c	2	1 ☐ Yes 2 💢 No 27. Manner of Death	1 _ Inpa		ER/Outpatien 28b. Time of			4 LA Nu		me 5 Reside				
n o	ding th. After fune	cate	1 X Natural 5 ☐ Pend	ing (Month, Di		injury	M 280	c. Injury a work?	es 2 🗌		28d. Describe ho	w injury occurr	ea		
Division of Vital Records,	il or Attending Physician: The law after death. Director: After this certificate has d in by the funeral director, page 2	Certificate:	3 Suicide 6 Could 4 Homicide deter	mined 28e. Place of In	jury - At hor tc. <i>(Specify)</i>						28f. Location (Si City or Town		er or Rural	Route Numbe	τ,
Ц	e Hospita 24 hours e Funeral	Medical	(Check 2 I Medical	g Physician: To the best o Examiner: On the basis of g Nurse Practitioner: To t	examination	and/or invest	igation, in m	y opinion,	, death oc	curred at	the time, date ar	d place, and du	e to the ca	use(s) and mani	ner stated.
	To the within to the comp	4	29b. Signature and title of certific				29c. l	License n	number	pid.		gd. Date signe	d (Month,		
			30. Name and address of person Susan J. Mill	who completed cause of er M.D., 821	death (Item 8 Wis	23a) (Type, P	rint) Aven	ue,	#305	, Be	thesda l	4D 2081			
	Sta Registra		31. Date filed (Month, Day, Year)	32. Regist	rar's Signati	far	W.							**	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 4:29 A M GERALDINE 05 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COURTS ARDEN MONTGOMERY POTOMAC 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Dominican Rep Hours Min. (Month, Day, Year) 1 M 2 D 80 08-04-1931 **Director** 212-32-7375 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20817 U.S.A. Page 1 and 2 should be filed within 72 hours after death with 8314 Still Spring Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Library 5+ Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Vera Poole Pierre Joseph Morin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 189 Buffalo Mountain Road, Glenville, NC 28736 Robert Bruce Carton/Son-in-Law altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Lincoln Crematory 05/22/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute Funeral & Cremation Ctr. MO15524 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ advanced disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events advanced I or Attending Physician; The law requires that the death certificate be executed after death. and resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) To the Hospital or Attentation...
within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attentation of the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director. in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 4 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 00057458 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue, Suite 305, Bethesda, Maryland 20814

Registrar DHMH 17 Rev 7/2009

State

Pinky Singh,

31. Date filed (Month, Day, Year)

M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 2012 Galen Ray Fleming, Sr. 05:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkton Care and Rehab Elkton Ceci1 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6.-Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days (Month, Day, Year) ay 1, 1942 Hours **Director** Yrs 225-56-6287 70 Grundy, Virginia Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XX No Maryland | Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Wetherbee Court 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1XXNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give ☐ Yes 2 🕅 No Specify: White Completed 3 Widowed 4 Divorced Specify: Year or Dates. US Marines 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Welder Chemica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ permit. Page 1 and 2 should be Department of Health and Ment: Important: If item 27 is marked Burns Fleming Jeanette (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Galen R. Fleming, Jr. / Son 11 Wetherbee Court, Elkton, Maryland injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State  $\frac{May}{20}$  $\frac{15}{2}$ 4 Donation 5 Other (Specify) Mayerdale Crematory Newark, Delaware Signature of Funeral Service Licenses 22. Name and Address of Facility Crouch Funeral Home, P.A. any 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Dementio disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ate has been signed by the a page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate performe Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital ٩ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical

41VA

DHMH 17 Rev 7/2009

State Registrar

29a. Certifier

29b. Signature and title of ce

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 HAHNAWAZ KHAN MD

USTINE HERMAN HWY

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0062190

CHESAPEAKE CITY

29d. Date signed (Month, Day, Year)

MD 21915

29c. License number

			1- For State of Marylan		artment o rtificate			nd M		giene Reg. No.	0	2	180	)75
	Physici	an	1. Decedent's Name (First, Middle, Last)  Betty L. Fo	or					2. Date of De Month May	Day 31	20	Year 012	3. Time (	of Death P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	<u> </u>	4b. City, To	wn, or l	_ocation of	Death	riciy		County of		1540	
	LAGIIIII		74 Hilltop Drive				ille				Ceci	i.1		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 \ Months D	Year Days	Hours	Min.	8. Date of Bir (Month, Da July 19	th y, Year) 192		Count	ace (State ry) sylva:	or Foreign nia
	iryland ihow	_		ty, Town or Lo						<del></del>		10		City Limits
	he Ma 8a-1 s	Directo		arlevi	lle 10f. Zip Co					10g. Citiz	on of Wh	ant Count		s 2 📉 No
	with t	Dir	74 Hilltop Drive			919				-	ited		-	
0	2 should be filed within 72 hours after death with the Maryland and Manall Hygiene. I and Manall Hygiene is marked other than "natural", or Items 23a or 28a-f ahow aumatic avant, I'ra Medical Evani ar must be notified at	y Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No			nt of His Cuban	panic Orig , Mexican, Specify:	in? (Spo Puerto	ecify Yes or No Rican, etc.)	)- 1	4. Race	- America , White, e	n Indian, tc.	
2-003e	72 hours 'natural', dical Ex	eted by	3 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual C	done du	tion uring most	of work	ing	16b. Kin	d of Busi	Whi iness/Ind		
717	ed within rgiene.  ar than ' t, the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		memake	r				L	omes			
yland	itd be file lental Hy rked oth ic avant	To Be (	17. Father's Name (First, Middle, Last)  Russell Watson						e (First, Middle [rvin	, Maiden S	Surname,	)		
Mary	d 2 shou th and M 7 is mar traumal		19a. Informant's Name/Relationship (Type, Print) Bonnie Aubry/Daughter						arlevil			tate, Zip		
e e	Pages 1 and 3 nent of Health int: If Itam 27 iry or other tr		20a. Method of Disposition 20b. F	Place of Dispo	sition (Name	of er place	)	June		20c. Loc	ation - C			
Dallillor	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 ia marke any injury or other traumatic once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		2. Name and	Address	of Facility		cks Hom	e for		nera	ls, P	.A.
	70 E # 0		23a. Part 1. Enter the disease, or complications that caused the deal					_	., E1kt		AD 2	2192	Approxima	ate
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the conditions, if any, leading to immediate cause of the conditions).  Due to (or as a consequence of the conditions).	tive b	rear!	L	rilue	··					Onset and	
,0070	certificate be executed  and in physician and in see as the burial-transit  and in physician and physician and in physician and physici	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence		litnal	ne	e yui	71	latio	7			Syn	\$
DOX O	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of constitutions of the past 12 months of the past 12 mon	al death 3[	Ectopic preg					2	3d. Date Mont		ry Day	Year
cords, r	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cau	se giver	n in Part I.		23e. Did 1	obacco us	_	oute to th		i death? ]Unknown
i con	law req nas beer e 2 shou	Completed	Diabetes mellitus type	2 2					24a. Was		pri	ere autori or to con	sy finding	s available cause of
		O	Hypertensian Combine	red h	spec-1		de m 26. Place		1 ☐ Yes	2 No			2 <b>1</b> No	
> 5	2 2 0	ToB		ER/Outpatier		Other				dence 6			)	
	ding Ph h. After th funeral	:lon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time o Injury	f 28c	Work'	at ? es 2□N		28d. Describe	how injury	occurre	d		
UNISION	spital or Attendours after death ours after deatheral Diractor: filled in by the	ertificat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Specific	ome, farm, str fy)					28f. Location ( City or To	Street and wn, State)	i Number	r or Rura	Route Nu	mber,
_	To tha Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my known one physician on the basis of examiner and manner stated.											(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	P.			number	7.20	,		_	•	Day, Year)	
			30. Name and address of person who completed cause of death (Iter	n 23a) (Type.	Print)	,	0	TT	c; 140	- 64	100	0 0	100	, ~
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signary	ature A	ohem	} a	HVE	Le	11/180	nj	ME	/ 1	191	ر

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan	d / Depa	artment o	of Heal	th and M	1ental Hy	giene	0016		076
			State Registrar			Cer	tificate o	of Deat	th		Reg. No.	2012	1 18	3U/b
	Physicia	ın/	1. Decedent's Name (First, Middle Barbara K	e, Last)						2. Date of De Month	Day	Year 2012	3. Time o	
11-18-	Medio Examin		4a. Facility Name (if not institution	n, give street and number)			4b. City, Tov	vn, or Locat	tion of Death	3		County of Deatl		3
mark				unland Medica	1 Cen	fer		more			B	alkmon	e City	
· · ·	Funeral Director		5. Social Security Number 212-50-6850	Sex 7. Age 1 □ M 2 💆 F	, ,	ast birthday)	If Under 1 Months D	Year If Un ays Hou	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da	th	9. Birt	hplace (State intry)	or Foreign
			Usual Residence of Decedent		65	Yrs.				8/5/19	146	Penn	sylvan	ia
	ryland -f sho ied at	ctor	10a. State 10b. County			y, Town or Lo							10d. Inside C	City Limits
	or 28a	Director	MD Cec	11	Ris	ing Su	n 10f. Zip Co	ode			10a Citiz	en of What Co		S Z KAN NO
	with the same same same same same same same sam	Funeral	430 Biggs High	way			219	11				ed Stat	-	
	death items		11. Marital Status	12. Was Decedent E	Ever in U.S	6. 13. V	Vas Decedent f Yes, specify	of Hispanio	c Origin? (Spe xican, Puerto	cify Yes or No- Rican, etc.)	1	4. Race - Amer Black, White		
36	after al", or xami	d by	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce	If You Cive	No	1	☐ Yes 2 🖸	X No Sp∈	ecity:		s	pecify: Whi		
21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed		ent's Education est grade completed)		16a. Deced	lent's Usual O	ccupation	most of worki	in a		d of Business/		
121	hin 72 ne. than " ie Mei	omb	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	life. Do	O NOT use ret	tired)	most of worki		Dub	lio Col	1.	
d 2	filed wit al Hygie d other event, th	Be C	17. Father's Name (First, Middle,			Speech	n & Lai			ologist e (First, Middle,		lic Scl	10012	
/lan	d be file	မ	James Clarence	Kerns						elyn Be				
Maryland	1 and 2 should be fill f Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relations									own, State, Zip	Code)	
	and 2: Health tem 27		Ray Groseclose  20a. Method of Disposition	- husband	20b. F		Biggs I sition (Name o		!	sing Su		ation - City or	Town State	
mor	0 <del>-</del> -		1 Burial 2 X Cremation 4 Donation 5 Other	3 Removal from State	,   0	emetery, cren	natory or othe	r place)	5/23 ome, P		ł .	ng Sun		
Baltimore,	permit. Page Department Important: I any injury o		21. Signatur I neral Service		-	22	. Name and A	ddress of F	acility R.T.	Foard	Fune	ral Hom	ne, P. <i>A</i> 21911	Α.
			23a. Part 1. Enter the disease, o	r complications that caused only one cause on each line									Approxima Interval Be	
2	nysician/		Immediate Cause (Final disease or condition	- a Interest	hihas	PCV	nonwy	Fibr	rsis				Onset and	
المسا	Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):								
		ner	Sequentially list conditions, cause. Enter Underlying	b. Due to or as	a conse	ience of it						10		
	cuted nd transit	Examine	Cause (Disease or injury that initiated events	с										
_	te be executed ysician and ne burial-transit	ical E	resulting in death) Last	Due to (or as	a consequ	ience otj:								
3760	ficate I g phys as the			d										
Box 6876	requires that the death certificate been signed by the attending phy should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth			Ectopic preg	nancy			2:	3d. Date of del	,	.,
Bo	e deat the at thed fo	ysici	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	at time of o	leath 5	Other (speci	fy)				Month	Day	Year
P.0	that th	by Ph	Part II. Other significant condition	ons contributing to death b	out not res	ulting in the u	nderlying cau	se given in I	Part I.	23e. Did t	obacco us	e contribute to	the cause of	death?
ds,	quires en sigl	ted t								1 🗆	Yes 2	No 3□Pr	obably 4 🔀	Unknown
Division of Vital Records,	sician: The law requires that the death certificate certificate has been signed by the attending phy lirector, page 2 should be detached for use as the	Completed										death?	opsy findings completion of	
		Be	25. Was case referred to medical examiner?	Hospital:	- 20	2	2	6. Place of Other:	Death (Check					0
λ	> 000	e: To	1 L Yes 2 X No 27. Manner of Death	1 Ninpati		ER/Outpatien 28b. Time of		Injury at		me 5 Resi	·· <del>·</del>	Other (Speci	fy)	
ou c	ath. r: After ne fune	icate		ng (Month, Day igation	y, Year)	injury	l	work?	_		1011 111,011			
Divisio	Hospital or Attending Physician: 44 hours after death: Funeral Director, After this certificately filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ				eet, factory, of	fice		28f. Location ( City or To		Number or Rur	al Route Num	nber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e g Nurse Practitioner: To the	xamination	and/or invest	igation, in my	opinion, dea	th occurred at	the time, date	and place, a	and due to the o	ause(s) and m	anner stated.
	To the by within 2.  To the Foundation completed		29b. Signature and title of certifie	r			29c. Li	cense numb	per		-	signed (Month		
0			MAIN	Rovy Bricker				9670			5,7	21,201	2	
,	4		30. Name and address of person	who completed cause of d	leath (Item	23a) (Type, P	rint)	201						
	Stat		31. Date filed (Month, Day, Year)	32. Regiver	ar's Signat	ure	parl	1				<del></del>	-	
	Registra	ar	HAI	्य दशाय	ساسلان	1	PARKE				_			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0934 AM 2RIFFIN 2012 DLLA Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Min 352-22-5532 82 Director 1 M 2 X F 10-12-1929 Illionis "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD . Prince George Camp Springs 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 5203 Oscar Ct IISA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 ★Widowed 4 ☐ Divorced Year or Dates er than "natur the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical LPN ed other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fitem 27 is marked of other traumatic even 2 Lillian Reese Pete Vancil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5203 Oscar Ct Camp Springs, MD 20748 Ramona J. Griffin daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Duquoin, Illinois ICOF Cemetery 05-23-2012 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. nterval Betweer STAGE Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) N Medical Due to (or as a consequence of): Examiner 4 EARS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ₹ 9 ☐ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2-→ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 2 No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: A 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse-Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and titley 29c. License number 29d. Date signed (Month, Day, Year) 2 nac completed cause of death (Item 23a) (Type, Print) Name and address of person who

Da

State Registrar nth, Day, Year)
MAY 18 2012

32. Registrar's Signature

445

DEFENSE

HNNAPOLS MD21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per inf G928 6/11/2012 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup> 2012 Month Jeffery Michael Geerts May 18 3:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22100 St. Clements Circle Great Mills St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4 / 27 / 61 482-84"0024 Birthplace (State or Foreign Country) **Funeral** 1 👿 M 2 🗆 F **Director** 482-82-0024 51 Iowa Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director St. Marys Great Mills 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 22100 St. Clements Circle 20634 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ▼ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. 1 Never Married 2 X Married than "natural", or Completed by 1 Yes 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Specify: 80 - 84Year or Dates. White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Aviation life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Equipment 12 Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Mental Important If item 27 is meany injury or other. ပ James Geerts Marilyn Haiston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22100 St. Clements Cr., Great Mills, Susan Geerts/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. : 5/21/12 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Raymond-Wood F.H., PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 s autonsy performe death? 1 Yes 2 No Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? After t Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Suicide nours after death neral Director: A I filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) M0055751 Jennifer Schmidt. ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 40900 merco rdtown, Mo 31. Date filed (Month, Day, Year) 32. Registra State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	State of Maryland	•	rtment of H tificate of D			giene <sub>Reg. No.</sub> 2 (	112	18079
	<b>*</b>		1. Decedent's Name (First, Middle, Last)				0447	2. Date of Dea		J 1 L	3. Time of Death
	Physicia		Mary Stokes Gr	ambo				May 28	, 2012	Year	6:15 a.m.
	Medic Examin		4a. Facility Name (if not institution, give stre	et and number)		4b. City, Town, or	Location of Death			ty of Death	
			23140 Cobblestone	Lane		Californ	ia		St.	Mary's	3
٠	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl		9. Birthp Count	lace (State or Foreign
	Director		577-22-3054 1 □ N Usual Residence of Decedent	<sup>M 2</sup> → F 93	Yrs.			01/26/	1919	Geor	oia
	and show at	ō	10a. State 10b. County		Town or Loc	ation		01/20/			0d. Inside City Limits
	Aaryla 8a-f : tified	Director	Maryland St. Mary's	Calii	ornia						1 ☐ Yes 2 🗓 No
	the Na or 2		10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?
	s 23;	Funeral	23140 Cobblestone	Lane		20619			United	State	s
	death item ner n		11. Marital Otatos	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No		as Decedent of His Yes, specify Cubar				ace - America ack, White, e	
5	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	If Yes, Give	1	☐ Yes 2 🛛 No	Specify:		Speci	fv.	
ş	nours natura ical E	Completed	15. Decedent's Educa			ent's Usual Occupa			16b. Kind of	Whit Business/Inc	
21215-0036	n 72 h an "n Medi	mp	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)		ind of work done do NOT use retired)	uring most of worki	ng			,
	withi giene rer th		Listing, y, sees many (s 12)		Teache	r			Educat	ion	
nd	tal Hy ed off	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surnai	me)	
Maryland	uld be I Men narke natic		Emory Joseph Stokes				Ethel Ire				
Ma	2 sho th and ?7 is r traur		19a. Informant's Name/Relationship (Type,			g Address (Street a			-		
	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mary Kathryn Rupard  20a. Method of Disposition	20b. Pla	ce of Dispos	Hawthorne sition (Name of		Chever Date	20c. Location		
آ ا	Page 1 ment of ant: If i ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	noval nom state		atory or other place iscopal C	· i	/2012	Chanti	oo MT	,
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		21. Signature of the ensee	CILL		Name and Address		nsfield			
ñ	on and per		Edward N. Brinsfi	leld, Jr. M000	)52 22	955 Holly					20650
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complications of the complete shock of the comple	ause on each line.							Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	WETASTAT	10 0	ANCEN	UNKNOW	IN 771	MANY		Onset and Death
أمميد	Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):						
		er	Sequentially list conditions, b.	pue to for as a consequer	GALCADA.					-	
	ed nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	105 01).						
	executed an and rial-transi	Еха	that initiated events c. resulting in death) Last	Due to (or as a consequen	nce of):						
09	ate be executed hysician and the burial-transit	dical	d.								
_	certificate be inding physicia use as the bu	Med	IF FEMALE:								
χ χ	h cert tendir or use	ian/	23c 23c 23c 23c 23c 23c 23c 23c	. If yes, outcome of pregnand 1 Live Birth 2 Fetal of	death 3	Ectopic pregnancy	/			Date of delive	1
Rox	the atte	Physician/Me	1 Yes 2 No	4 Pregnant at time of dea 9 Unknown	ath 5∟	Other (specify)				/lonth	Day Year
л. О.	law requires that the death certifica nas been signed by the attending p e 2 should be detached for use as	/ Ph	Part II. Other significant conditions contri	buting to death but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use co	ntribute to th	e cause of death?
S,	ires the signer ld be	d by						1 🗆 🕆	Yes 2 JAO	3 🗆 Prob	oably 4 🗆 Unknown
ord	requ been shou	Completed						24a. Was a	an 24b	. Were autop	osy findings available
ě	ne law e has age 2	omp						autop perfo	rmed?	prior to cor death? 1  Yes	mpletion of cause of
<u>e</u>	an: Ti tifical tor, p	Be C	25. Was case referred to medical			26. Pla	ice of Death (Check	_	INO	i 🗆 ies	2 🗆 NO
<b>X</b>	nysici nis ce I direc	70 E	1 L Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ El	R/Outpatien	Othe	r: 4  Nursing Ho	me 5 🔀 Resid	dence 6 🗆 O	ther (Specify)	)
0	ing Pl		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work?	?	28d. Describe h	ow injury occu	ırred	
ion	ttendideath death tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	OSa Plana of Injury. At home	- farm atra		Yes 2 No	OOS Laastina (C	\.	aban an Dunal	Pauta Alumbar
Division of Vital Records,	l or A	Cer	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, iarm, sire	et, factory, office		28f. Location (S City or Tow		iber or Hurai	Houte Number,
_	ospita hours neral y filled	Medical		n: To the best of my knowled							
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Mec		On the basis of examination a ractitioner: To the best of my							
	To To Con		29b. Signature and title of certifier	20.4	^	29c. License	number		29d. Date sign	ned (Month, I	Jay, Year)
				n.		<u>D</u>	16006		5-	29-	12
R	me		30. Name and address of person who com Rajbinder S. Gill,				and 11-11	···· - 1	MD 00	626	
1	Stat	e	31. Date filed (Month, Day, Year)	3 Registrar's Signatur	е	Notch Ro	pau, HOLI	ywood,	MD 201	636	
	Registra		MAY 3 1 2012	Cerus B.	par	KN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Year Gessner 15, 9:27 pM Adolf Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Examiner 4c. County of Death Montgomery 3013 Birchtree Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 003-22-5392 Director 1 2 M 2 □ F 83 Yrs Aug. 26, 1928 Germany Usual Residence of Decedent of Health end Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28e-f show other treumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20906 3013 Birchtree Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 72 hours efter Specify: White 1 ☐ Yes 2 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Chemical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health end Mental Importent: If Item 27 is marked or any Injury or other treumetic ew ൧ William Gessner Nelly Geyger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Gessner/Wife 3013 Birchtree Lane, Silver Spring, MD 20906 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State May 18 2012 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. University BLvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Parkinsonism Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sacral Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ettending physicien and I for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed lirector, pege 2 should be de Completed by Records. 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 N 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification in the funeral director. of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital 1 Yes 2 3 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 2 M Accident 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License numbe 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

April Tweedt, MD

22 2012

31. Date filed (Month, Day, Year)

18109 Prince Philip Drive, Olney, MD 20832

May 18, 2012

			AM	Pleas END #25, PER ME G	e Type or P 929 7/17/ State of	rint in 12 TR Marvian	Black Ir T nd / Depa	ndelible artment	e Ink	<b>c. Ens</b> i lealth a	ure Al	I Copie ental Hy	s Are	e Legil	ole.	
				1 - For State Registrar		,		tificate				,	Reg. N	201	2	18081
				Decedent's Name (First, Middle, L.)	ast)						T	2. Date of De	eath		Bogge	3. Time of Death
		Physicia Medi		Eugene Carlton	Grimes,	Jr.						Month 05	24	ay 201	⁄ear 2	11:55 P <sup>M</sup>
4	-	Examir		4a. Facility Name (if not institution, gi	ve street and numbe	r)		4b. City, To			of Death			c. County of		
				Southern Maryla				Cli			Od Hen			ince		
	~	Funeral Director		· .	1	Age (In yrs. I		If Under 1 Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	rth a <i>y</i> , Yea <i>r)</i>		9. Birth Coun	place (State or Foreign htry)
			•	Usual Residence of Decedent	1 💢 M 2 □ F	76	Yrs.					04/24/	1936	M	ary	land
0.		land show dat	호	10a. State 10b. County			ty, Town or Lo	cation							-	10d. Inside City Limits
34		Mary 28a-1 otifie	Director	Maryland Prince	George's	Aqua	asco	,								1 Tyes 2 X No
Mar	•	th the	] <u>a</u>	10e. Street and Number	1			10f. Zip C					_	itizen of Wh	at Cour	ntry?
2		ms 2 must	Funeral	22701 Aquasco Ro	12. Was Decede	nt Ever in 111	6 112 1		_	enania Oria	ain? (Spec	ifu Vas ar Na			A a	
1.	(0	or ite	Į.	11. Marital Status 1 ☐ Never Married 2 🔀 Married	Armed Force	s?	3. 113. I	Yes, specify	y Cubar	n, Mexican	n, Puerto R	ify Yes or No lican, etc.)			White,	etc.
3	036	rs afte iral", Exar	ed	3 Widowed 4 Divorced	1 X Yes 2 If Yes, Give Year or Dates	5.	1	☐ Yes 2	X No	Specify:				Specify:	Whi	te
1	21215-0036	2 hour	Completed by	15. Decedent's (Specify only highest				lent's Usual kind of work			t of working	a	16b.	Kind of Busi	ness/In	dustry
	121	hin 7% ne. than	E O	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. D	O NOT use re	etired)			9		Groce	ry	Store
t i	2	ed wit Hygie other	Be	17. Father's Name (First, Middle, Las	•)		Store	e Owne	r -			(First, Middle	Maider	Surname		
D	an	be file ental ked c	2	Eugene Carlton G	*							smith				
1	Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ıg Address (S	Street a	and Numbe	er or Rural	Route Numb	er, City c	or Town, Sta	te, Zip (	Code)
P	Ž	d 2 shalth a alth a 127 is		Barbara Ann Grime	s / Wife		2270	l Aqua	sco	Road	l Aqı	uasco,	MD	2060	8	·
R	ore,	of He fitem		20a. Method of Disposition	Dameural from St		Place of Dispo	sition (Name	of ner place	e)	Da	ate	20c. l	Location - C	ity or To	own, State
2	Ë	Page ment ant: I		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Tri	nity M		-		5/31/	2012	Wa:	ldorf,	, Ma	ryland
B	3alt	permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	nsee MOC	817										ral Home, P
	_	_ = a o		Haufon C.	ochor	) 111-								otte H	all	, MD 20622
				23a. Part 1. Enter the disease, or co shock, or heart failure. List only	one cause on each						cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
4	1	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a		LOMY	DPA	1/4	7					_	Chock and Dodg
		Examiner			Due to (or	as a consequ	uence oi):						. /	1//		
	Щ		ner	Sequentially list conditions, list years got a list in realth cause. Enter Underlying	b. Due to for	as a consed	uence off:					100	1	AMINER		
		executed in and ial-transit	Examiner	Cause (Disease or injury that initiated events	C						7	ROVED BY III.	CALL		11	_
			1=1	resulting in death) Last	Due to (or	as a consequ	uence of):			CERT!	FICATION AS	1				
	9	icate be e I physicial is the buri	gi	•	d										+	
	687	ath certifica attending p I for use as I	Completed by Physician/Medica	IF FEMALE:	23c. If yes, outcor	me of pregna	ancv							20 1 5 1		
	XO	ath co	cial	23b. Was decedent pregnant in the past 12 months?	1 Live Birl	th 2 🗌 Feta	al death 3 🗌	Ectopic pre		У			- 1	23d. Date Mont		ery Day Year
	W	he de y the iched	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗌 Unknow											
	P.0	es that the dea igned by the a be detached t	N P	Part II. Other significant conditions	1	h but not res	sulting in the u	nderlying ca	use giv	en in Part	l.	23e. Did	tobacco	use contrib	ute to ti	he cause of death?
	JS,	requires been sig should b	ed	Digoxin To	4 aty							1 🗆	Yes 2	2 □ No 3	☐ Pro	bably 4 Unknown
	Ö	w rec	plet	0								24a. Was		24b. We	ere auto	psy findings available empletion of cause of
21.5	Rec	The Iz	l E									perf	ormed2	dea	ath?	2 🗆 No
	ā	ysician: The law I s certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	Hamitali /				1	ace of Dear	th (Check o	only one)				
	Ξ	Physic this or	은	1 X Yes 2 No 27. Manner of Death			ER/Outpatier		_	4 ∐ Nı		ne 5 🗆 Res			(Specify	)
	0 1	ding h. h. After funer	ate	1 Natural 5 ☐ Pending		Day, Year)	28b. Time of injury	M 280	c. Injury work	rat ? Yes 2. □		8d. Describe	how inju	iry occurred		
	Sio	I or Attendi after death. Director: A d in by the f	Certificate:	2 Accident Investigat 3 Suicide 6 Could not	be 280 Place of	Injury - At ho	ome, farm, stre			- 2		8f. Location	Street a	nd Number	or Rura	l Route Number,
	Division of Vital Records, P.O. Box 68760	al or / s after I Dire		4 ☐ Homicide determine		etc. (Specif)		,,,				City or To				
	_	ospital hours a uneral C	Medical		nysician: To the best											
		To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Mec	only one) 3 Certifying N	miner: On the basis ourse Practitioner: To											use(s) and manner stated. stated.
		To t Com		29b. Signature and title of certaier	LANKS			29c. l	License	number	10:		29d. D	ate signed (	Month,	Day, Year)
				19h	MYNC	/			DÜ	1/4	121			0/21	5/1	1
	10	. /		30. Name and address of person who	odompleted cause of HIABO				1 447		11 14	DIO TA	1	,		
(6)	(ILL	Sta	te	31. Date filed (/ Arg() Pag Yar)	32. Redi	strar's Sign	ture	A THEKA	; j*1+	יושיין	א נבי	05017A	_			
$\vee$		Registr		MWIGIS	12 senen	v p.	gar									

12-04044	
----------	--

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lizabeth Joanna l	1	- For State	State of Maryla		artment o		d Mental H		Con No	20	12 18	80
Physician		<b>Registrar</b> 1. Decedent's Name (First, Midd	dle,Last)				·	2. Date of Dea			3. Time of Dea	ath
Medical Examine	er :	Elizabeth Joa						Month May 28, 2	Day 2012	Year	1120 hrs	<b>;</b>
	4	4a. Facility Name (if not institution		mber)		4b. City, Town, or	Location of Deat	th		County of D		
		18131 Marksman Co				Olney	T	Ta = 1 4=		ontgome	<u> </u>	
Funeral Director	1	5. Social Security Number		7. Age (In yrs.	last birthday)	Months Days		n		F	<ol> <li>Birthplace (State of oreign)</li> </ol>	
Director	L	217-36-8849	1 M 2 X F	72	Yrs			June 1	18, 1	939 W	Vashingtor	ı, DC
kine kine		Usual Residence of Decedent 10a, State 10b, County	<i></i>	10c. City	, Town or Locat	tion					10d. Inside Cit	ity I imits
<b>*</b>						.1011					1 Yes 2	
rylanc na-f sh	ē-	MD M 10e. Street and Number	Montgomery		01ney	10f. Zip Code		-	10a Citiz	en of What		
5-0036 led within 72 hours after death with the Maryland alygene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	1		Cimala	A 4s	/ 0.1		0				Country :	
orth th		18131 Marksm		Apt. 4		2083		enerify Yes or N	USA Io- I		American Indian, Blad	nck
er death with , or items 23	2	1 Never Married 2 N	Married Armed Fo	orces?		res, specify Cuban			)- I	White, e		CK,
fter de		3 Widowed 4 XXDi	1   Yes ivorced If Yes, Give Year	2 X No	1	Yes 2 X No	specify:		٤	Specify: W	hite	
ours a stura	<u></u>	15. Decedent's Education (Spe	ecify only highest grad	le completed)		nt's Usual Occupat	tion (Give kind of				ness/Industry	
72 hg 12 hg 12 hg 12 hg		Elementary/Secondary (0-12)		-4 or 5+)	- dunng m	nost of working life.	. DO NOT use re	tired)				
5-0036 ed within 7. lygiene. other than	Сощріете		2		Но	memaker				wn Hoi	me	
		17. Father's Name (First, Middle					18.Mother's Nam					
P se p 2		Charles Arthu			1.00. 14-95.	111 1 (0)		le Eliza				
O & Bigger	-	19a. Informant's Name/Relations Kenny Charles			1.0	g Address (Stree						
	-	20a. Method of Disposition	Kailii/ Soii	20b.		Canada G		Date Date			ity or Town, State	
		1 Burial 2 X Crematio	on 3 Removal fro	om State	crematory or ot	her place)		y 31, 2012				
ti. Pag treent runt:		4 Donation 5 Other S	Specify:	Met		an Cremat			-		ria, VA	
Baltimo permit. Page Department t Important:	1	21. Signature of Funeral Service	Licensee		Fr	Name and Address ancis J.	Collins	Funera	1 Ho	me In	с.	22201
Physician	+	23a, Bart I. Enter the disease, or	or complications that ca	aused the death	Do not enter t	Univers	SITY BIV	or respiratory ar	S11V	er Spi	ring, MD	
Medical		failure. List only one cause	e on each line.						1004	#4	Between On Death	nset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			10Vascu <sub>1</sub> a	ar Disea	ise				
		Sequentially list conditions,	b									
jo	<u> </u>	if any, leading to immediate	Due to (or as a	consequence o	of):						- 2	
Fyamine		(Disease or injury that initiated events resulting in death) Last	С.	consequence o	of):							
and trans	į	270/10 - 222g 222,	d									
0, be executed sician and unial - trans	2	X UNPENDED	AMENDED 2	23a,27,	per me,	g929 7-10	0-12 sm					
		F FEMALE:		outcome of preg	gnancy				23d.	Date of del	livery	
cath certificate attending physical for use as the besident.	<u> </u>	3b. Was decedent pregnant in t past 12 months?	I I I I I I I I I I I I I I I I I I I	irth ant at time of de	a oth	etal death 3 [	Ectopic pregn	ancy	N	Month	Day Ye	ear
	2	1  Yes 2  No 9  Un	nknown 9 Unknow		eath 5 Ot	ther (Specify)						
that the dined by the detached		Part II. Other significant condi			resulting in the ι	underlying cause g	jiven in Part I.	23e. Did t	tobacco u	se contribut	te to the cause of de	ath?
ires that signed I be deta								1 Ye	s 2	No 3	Probably 4 🗹 Uni	known
ords, w requir	100							24a. Was			re autopsy findings a	
Records,  The law require, freate has been sign, agge 2 should be.	호								ormed?	deat		
tal Recting The Certificate ector, page		25. Was case referred to medica	al			26 Place	of Death (Check	1 Yes	2 No	1 💆	Yes 2	No
Division of Vital Records, P.O. B. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached chiral Contification: To Re Commissed by Dh.	ŏ	examiner?	Hospital:	npatient 2	ER/Outpatient		Other -		Residen	ce 6 🗸 (	Other: Scene	
ding Phy	-  -	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	of Injury	28b. Time of I		ry at Work?	28d. Describe			74101. OCC	
endin ath.	5		nding	Day, Year)		1 Y	Yes 2 No					
Division tal or Attendin rs after death. al Director: A led in by the fu	2		estigation 28e. Place	of Injury - At h	nome, farm, stree	et, factory, office b	uilding, etc.			d Number o	or Rural Route Numb	per, City
Division o spital or Attending tours after death. neral Director: After filled in by the fune.	<u> </u>		ermined (Specify)					or Town,	State)			
Host 24 ho Pun erely f		one on	Physiclan: To the best	-	-		•					
Division To the Hospital or Attention 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Madical Cortification	֓֞֞֟֞֟֟֓֟֟֓֟֟֓֟֓֟֓֓֟֟֓֓֟֟֓֓֟֟֓֓֓֟֟֓֓֓֓֟֟֓֓֓֟		aminer: On the basis of and manner sta		and/or investigat	tion, in my opinion,	, death occurred	at the time, date	and plac	e, and due	to the cause(s)	
	Ē 2	29b. Signature and title of certific	er	9.5		29c. License		20145	29d. Da	ate signed	(Month, Day, Year)	
SPEND		There.	Mr Kin	2 TR	. 14.1	O.C.N	M.E.	OCME	May	29, 2012	2	
	3	30. Name and address of person			/	· · · · · · · · · · · · · · · · · · ·						
	┵	Theodore M. King, Jr.				900 W. Baltim	nore Street, E	3altimore, M	D 2122	3		
Stat Registra	~	31. Date filed (Month, Day, Year)	112 A32. Rec	gistrar's Signati	harts	1						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	-	epartment of F Certificate of L		, 0	2011	2 18083
			Registrar  1. Decedent's Name (First, Middle, Last)		ertificate of L	Jeath	Re 2. Date of Death	g. No. <u>U</u>	3. Time of Death
	Physicia Medic		James Wallace Hancock,	III			Month 05	Day Year 18 2012	
	Examir		4a. Facility Name (if not institution, give street and number) PUNINSULA BIGIONAL MIDICA	L Centre	/	Location of Death	1	4c. County of Dea	ath .
	Funeral Dírector	Γ		n yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) C	irthplace (State or Foreign ountry)  MD
	show d at	į		0c. City, Town or	Location	<u> </u>			10d. Inside City Limits
	e Mary 28a-f notifie	Director	MD Worcester	Ocean					1 ¥ Yes 2 □ No
	vith the 23a or st be r		10e. Street and Number 427 14th St. #301		10f. Zip Code 2184	2	10	g. Citizen of What C USA	ountry?
	leath v	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	r in U.S. 1	Was Decedent of Hi	ispanic Origin? (Spe	cify Yes or No-	14. Race - Am	
Baltimore, Maryland 21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	ted by	1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.		If Yes, specify Cuba  1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, Whi	
15-(	72 hou n "nati fedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occup ive kind of work done o b. DO NOT use retired)		ng 1	6b. Kind of Business	s/Industry
212	within 7. giene. er than t, the Me		Elementary/Secondary (0-12) College (1-4 or 5+)		olice Of:	ficer	]	Law Enfo	rcement
pue	e filed wit ntal Hygie ed other event, th	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma		
aryla B	should be file n and Mental I 7 is marked o raumatic eve	_	James W. Hancock, Jr.  19a. Informant's Name/Relationship (Type, Print)	10b M	ailing Address (Street a	Ann Cou		T	"- O-d-)
MS.	nd 2 sh salth ar n 27 is er trau		Martha Seibert / sister	- 4	4 N.W. 1				
ore	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once."		1 Rurial 2X Cremation 3 Removal from State	20b. Place of Dis	sposition (Name of crematory or other place	e) [	Date 2	0c. Location - City o	r Town, State
Iţim	artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Sig ur) Fun Service Lice See		State Cre				
Ba	Depar Depar Impor any in		1. full autale			liam St.	, Berli	in, MD 2	
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			g, such as cardiac c	r respiratory arrest	,	Approximate Interval Between Onset and Death
eller V	Medical		disease or condition resulting in death)  a. Due to (or as a co	ons author of:	COVO				Unset and Death
	Examiner			U					
	si sq	niner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury)	onsequence of):					
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):					
09	te be e nysicia he bur	edical	d						
687	ertifica ding ph se as t		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of p	oregnancy					
. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending plompletely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director, page 2 should be detached for use as the form of the funeral director.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	Fetal death	3	у		23d. Date of de Month	elivery Day Year
P.O.	s that t gned by	by	Part II. Other significant conditions contributing to death but r	not resulting in th	e underlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rds,	equire een si hould l	eted					1 🗌 Yes		Probably Unknown
Division of Vital Records,	sician: The law r s certificate has b director, page 2 s	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
/ital	sician; certifii	m	25. Was case referred to medical examiner?  1  No Hospital:		Otho	ace of Death (Checker:			
of \	ig Phy ter this neral d	te: To	27. Manner of Death 28a. Date of injury	2 ER/Outpat 28b. Time ear) injury	of 28c. Injury	4 Nursing Ho	me 5 L. Resideno 28d. Describe how	ce 6 Other (Special Control of Co	oify)
ion	tendin leath. tor: Aff the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2 No			
Divis	al or Attendi s after death al Director: A ed in by the f		4 Homicide determined 28e. Place of Injury - building, etc. /S	· At home, farm, s ipecify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
_	To the Hospital or Attending Physician. The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam 3 Certifying Nurse Practitioner: To the best of my 2 Certifying Nurse Practitioner: To the best of my 2 Certifying Nurse Practitioner: To the best of my 2 Certifying Nurse Practitioner: To the best of my 2 Certifying Nurse Practitioner: To the best of my 2 Certifying Physician: To the best of	nination and/or inv	estigation, in my opinio	n, death occurred at	the time, date and i	place and due to the	cause(s) and manner stated
	70 t with 70 tl		29b. Signature and title of certifier		29c. License	number		d, Date signed (Mont	
5	1811		30. Name and address of person who completed cause of death		e, Print)		CALLED	1.01	21001
	Stat Registra	e	31. Date filed (Month, Day, Year)  MAY 2 1 2012  32. registrar's	Signature	banks	الله الله	30101313	NO MIN	7 4 8 9 7 ,
			THE LOTE CANON	10.19	F (F W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Verna Allene Harris MA 142 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Riverdale Prince George's Crescent Cities Center Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Davs Hours Min. 1 □ M 2 □ F May 19, 1923 Director <u>577 26 1818</u> Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ita Novice Examine must be rediffed. 1 □Yes 2□No Directo Prince George Upper Marlboro Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20772 6205 Richmanor Terrace Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2□No If Yes, GiveXX Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Y Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 12 Industrial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Gable Foster George Woodson Mundy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 6205 Richmanor Terrace, Upper Marlboro, MD 20772 Joseph G. Harris, Jr. (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Maryland Veterans Cemetery May 22, 2012 Cheltenham, MD

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sign ture of Funeral Service Liceuse Ferry Road, Clinton, MD 20735 MOOA57 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final 110516 LYEAR **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical After this certificate has been signed by the aftending I funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 🔼 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed nom bosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

60.30

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 1 2012

repleted cause of death (Item 23a) (Type, Print)

SE MD 4 W3 Queonsbury Rd / tyattsvilk Mg 20781

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

d. parket

			Plea	se Type or Pi							egible.		
	•	For State Registrar		State of N	viaryian		artment of F rtificate of L			eg. No. 2	012	18	085
Physicia	n/	1. Decedent's Name							2. Date of Deat Month May 24	Day	Year 2	3. Time of	Death a.Mn.
Medic Examin		Robert  4a. Facility Name (if	Richa not Institution,	rd Hays give street and number,	)		4b. City, Town, or	Location of Death	May 22		nty of Death	111:30	Ja.m.
LAGIIIII		St. Mary	y's Hos	pital			Leonard	town		St.	Mary's	5	
Funeral		5. Social Security No	umber			ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 06/11/	Year)	Cour	place (State o	_
Director		175-16-28 Usual Residence of	057		93	110.			06/11/	1918	Penns	sýlvan:	Lä
yland f shov ed at	tor	10a. State	10b. County			y, Town or L						10d. Inside Ci	ity Limits 2 🗶 No
r 28a- notifie	Director	Maryland 10e. Street and Nun		ry's	Leor	nardto	wn 10f, Zip Code			10a Citizen	of What Cou		S Z LALINO
vith th		40325 Dry					20650			_	State		
eath v	Funeral	11. Marital Status	ury Lai	12. Was Deceden Armed Forces		S. 13.	Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. F	Race - Ameri	can Indian,	
after d	by	1 🗌 Never Marri 3 ื Widowed		ied 1 🔀 Yes 2 [ If Yes, Give			1 ☐ Yes 2 🛣 No			Spec	Black, White,		
2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	letec		15. Deceder	Year or Dates.	-	16a. Dece	edent's Usual Occup	ation	- T	16b. Kind o	Whi f Business Ir		- 1
in 72 l e. nan "r	Completed	(Spe		st grade completed)  College (1-4 o	r 5+)	(Give	kind of work done on NOT use retired)	during most of work	ing				
d with Hygien ther th	Be C	17. Father's Name (i	Eirst Middle I	4	_	Commu	nications	Analyst  18. Mother's Nam			Servi	ce	
be file ental F ked o ic eve	70 E	Dana McG						Grace Ca					
hould and M is mar		19a. Informant's Na				19b. Mai	ling Address (Street					Code)	
ind 2 s lealth : im 27		Sally J.		)aughter			Box 283,					- 0. /	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation	3 Removal from Sta	te	cemetery, cre	osition (Name of ematory or other place	ce)	Date		on - City or T		
nit. Pa lartme lortan injury		4 Donation	5 U Other (S	inecity)	Get	tysbu	rg Nationa 22. Name and Addre		[/2012 <u> </u> insfield				Δ
permit Depar Impor any ir once.		Micher		ATELY MOT		2	2955 Holl	ywood Roa	ad, Leon	ardtow			
				complications that cause only one cause on each I	sed the deat ine.	h. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximat Interval Bet Onset and	tween
nysician/ Medical		Immediate Cause ( disease or condition resulting in death)		a	Low.		ACTROZNI	ESTEAML	BLEED			Offiset and	Death
Examiner				Due to (or a	is a conseq	uerice orj.							
- ±	Examiner	Sequentially list co in any, leading to in cause. Enter Unde	nmediate erlying	b. Due to (or a	ia a conseq	dence oi).					201		
executed an and rial-transi	xar	Cause (Disease or that initiated event resulting in death)	s	c. Due to (or a	as a conseq	uence of):							
be executed sician and burial-transit		Tooding in down,		d	,			_					
ificate ng phy as the	Physician/Medical	IF FEMALE:											
th cert ttendir or use	ian/	23b. Was decedent in the past 12			h 2 🗆 Fet	al death 3	☐ Ectopic pregnan	су		23d.	Date of deli	,	Year
ne dea / the a ched fi	ysic	1  Yes 2 Dunknown		4 ☐ Pregnan 9 ☐ Unknow		death 5							
that the ned by e detail	by P	Part II. Other signif		ons contributing to death			underlying cause gi	ven in Part I.				the cause of c	
equires sen sig ould b	ted			TIC STEN							`	obably 4 🗌	
law re has be	Completed		Core	CONARY AR	TERY	" nz	SEASE		24a. Was a autop perfoi	sy	4b. Were auto prior to c death?	opsy findings ompletion of o	available cause of
n: The ficate or, pag	e Co	25. Was case referr	red to medical				26 P	lace of Death (Chec	1 Yes	2 2 40	1 Yes	2 No	
ysicia is certi directe	To Be	examiner?		Hospital:	atient 2	BR/Outpati	ent 3 DOA Oth	ner:	ome 5 Resid	ence 6 🗆	Other (Specia	fy)	
ing Ph ifter th ineral		27. Manner of Deat	:h 5 ☐ Pendi	28a. Date of in (Month, i	njury Day, <i>Year)</i>	28b. Time injury	wor	k?	28d. Describe h	ow injury oc	curred		
ttendi death stor: A	Certificate:	2 Accident 3 Suicide	Investi	not be 280 Place of	Iniury - At h	ome, farm, s	M 1 ∟ treet, factory, office	Yes 2 No	28f. Location (S	treet and Nu	mber or Run	al Route Num	ber.
al or A s after il Direction by	Cer	4 L Homicide	detern		etc. (Specif		,,,		City or Tow				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director After, this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burning the property of the funeral director, page 2 should be detached for use as the burning that the funeral director, page 2 should be detached for use as the burning that the funeral director is the property of the funeral director.	Medical	(Check 2	2 Medical I	Physician: To the best Examiner: On the basis of Nurse Practioner: To t	of examination	on and/or inve	estigation, in my opini	ion, death occurred a	at the time, date a	nd place, and	d due to the c	ause(s) and ma	anner stated.
To the within To the comp	2	29b. Signature and			inc best of th	ly Milowicage	29c, Licens	se number	-	29d. Date si	gned (Month,	, Day, Year)	
		14	2 Cole	mo			106	+840		5/2	4/201	17	
Derne		30. Name and addr	ress of person	who completed cause of	of death (Iter	m 23a) (Type	Print)	OKERIT RE	DAP USO	NARIOT	trun 1	np 20	650
Sta													
Registr	ar		MAYZ	9 2012	ma_	P. 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Cer	tificate of	Death	Reg	J. No.	
	Physici		1. Decedent's Name (First, Middle, Last).  Macu	rley				2. Date of Death Month	Day Year	3. Time of Death 2 12:34PM
	/Medi Examir		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
			Bradford Oaks Nursi	ng Home		Clinton			Prince Ge	orge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		214 58 0747 Usual Residence of Decedent	X 89	Yrs.			April 11,	1923 Mar	yland
	land		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	Marylan f show	Ö	Maryland Prince Georg	roia Di		II				1 ☐ Yes 2007No
	1 the	Director	10e. Street and Number	ge s DE	STITICE	Heights 10f. Zip Code		100	g. Citizen of What Co	ountry?
	h with		6204 Belwood Stree	et		2074	7		United Sta	atos
	death	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of H	lispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian,
9	after or Ite	正	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ₩ No If Yes, Give A			Specify:	nican, etc.)	Black, Whit	le, etc.
93	ours!,	d by	3 N Widowed 4 □ Divorced	Year or Dates:		Yes 2 No	ороспу.		Specily.	Black
21215-0036	within 72 hours after death with the Maryland ane than "natural", or Items 23s or 28s-f show to Madical Eventre mat be rotified at	Completed	15. Decedent's Éducat (Specify only highest grade o	on ompleted)	(Give k	ent's Usual Occup kind of work done OO NOT use retired	during most of worki	ing 16	6b. Kind of Business	/Industry
12	withir ene. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemal		4)		O II	
	filled Hygi ther		17. Father's Name (First, Middle, Last)		TICHE	NC1	18. Mother's Name	(First, Middle, Ma	Own Home	
an	id be ental ked c	To Be	Albert Savoy				Pear	1 Swann		
Maryland	12 should be filed within 'n and Mental Hygiene. 7 is marked other than "r	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing	g Address (Street	and Number or Rura		City or Town, State, .	Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, It a Madical Examinar must be cutified at		Joseph P. Savoy (Son	)	6208	Belwood St	treet, Distr	ict Baiobte	mi) 20747	
J.e.	ss 1 a of He item		20a. Method of Disposition	000	ce of Dispos	sition (Name of patory or other place		Date 20	c. Location - City or	Town, State
Ē	Pages nent of i ant: if it		1 Magarial 2 ☐ Cremation 3 ☐ Rem 14 ☐ Donation 5 ☐ Other (Specify)	oval from State			ery May 25	2012	linter MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other trau		21. Signature of Funeral Service Vicensee	- 4	22.	Name and Addre	ss of Facility Lee	Funeral Hor	ne.Tnc.6633	Old Alexandria
_	90 2 2 9		Moris & Fran	A mod257		Ferry Road	l, Clinton, l	MD 20735	, 0000	old Heddeldi III
п			234. Enter the disease, or complicat shock, or heart failure. List only one of	ause on each line.				1	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cerebrol	rasc	war	ACCI	ident		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque		,				
		-	Sequentially list conditions, b.	Due to (or as a conseque	DOM.	/a				
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	1100 01).					
,	sicien and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a conseque	nce of):					
68760,	icate be exi physicien a s the buriat-		L <sub>d</sub>							
68	tificat ng phy as th	Medicai								
Вох	The law requires that the death certificate be executed the has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	_	23b. Was decedent pregnant	If yes, outcome of pregnand 1□Live birth 2□Fetal d		Ectopic pregnancy	,		23d. Date of de	,
_ 0	ne death the atte hed for	Physician	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant at time of dear 9☐Unknown		Other (specify)	·		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown				1.0.41	an- Dida-b-		- Ab
ţs,	uires tha signed Id be de	by	Part II. Other significant conditions contrib	luting to death but not resulti	ing in the un	derlying cause giv	en in Part I.			o the cause of death?
0.0	w requ been should	etec						: : : : : : : : : : : : : : : : : : : :	<del></del>	
Vital Record	e law has t	Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
<u>a</u>								1 ☐ Yes 2	No 1 ☐ Yes	s 2 No
Z.		o Be	25. Was case referred to medical examiner?	pital:		Oth	26. Place of Death			
of	Phyter this stal di		1 Yes 2 No		NOutpatient 8b. Time of	3 DOA	Nursing Hor	me 5∐Residen 28d. Describe how	ce 6 Other (Spe	icify)
on	Attending F r death. sctor: After by the funer	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No		.,,	
Division	i or Attendi after death. Director: A i in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be	8e. Place of Injury - At hom	e, farm, stre	et, factory, office		28f. Location (Stre	et and Number or R	ural Route Number,
Ö	s after bi Direct	Certification:	4   Homicide	building, etc. (Specify)				City or Town,	State)	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier (Check only 2 Medical Examiner	an: To the best of my knowle	edge, death	occurred at the tir	ne, date and place,	and due to the cau	se(s) and manner a	s stated.
	the H in 24 the F	ledical	one)	On the basis of examination and manner stated.	m and/or invi	estigation, in my o	pinion, death occurr	ed at the time, dati	e and place, and due	of the cause(s)
	To To	Σ	29b. Signature and title of certifier	- h (10	NIA	29c. Licens			I. Date signed (Moni	
,	56		* Helsy All	onk cer	- 00	1100	172/	MO C	17,11	2012
	oll		30. Name and address of son who comp	leyed cause of death (Item)2	3a) (Type	Print)	G / n	Llina	nin	20711
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	() () ()	UN 70	2/407	or cert	1000	40111
	Registr		MAY 22 2012	Down &	9. 400	all				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2012° HERMAN AUGUSTUS 2:55 P M HURD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MEMORIAL HOSPITAL FREDERICK FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Hours **Director** 219-66-4512 1 X M 2 🗆 F 89 Vrs AUG. 9, 1922 Jamacia Usual Residence of Decedent show 10a. State filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Frederick Frederick 1 X Yes 2 No 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 21702 2100 Whitehall Rd./Unit Bd United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black. White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Iron & Steel Industry Core maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Herbert Hurd Adeline Lumb1v permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 Whitehall Rd/Unite B-d /Frederick, MD 21702 Hurd / Wife Anna Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 05/19/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery Signature 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pulmonary Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician; The law requires that the death certificate be executed Dementia resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. 1 Ves 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Records, P.O. Division of Vital filled in by pletely

> State Registrar

(Check

only one) 29b. Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

C strar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c License number

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10a. State 10b. County 10c. City, Town or Location the Maryland Director notified 28a-f MD Montgomery Rockville 10e. Street and Number 10f. Zip Code items 23a or ner must be n Funeral 20852 5801 Nicholson Lane, #325 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Armed Forces? ō by 1 XNever Married 2 Married 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Disc Jockey 12th Be Maryland 17. Father's Name (First, Middle, Last) မ Ali Hamzehnaza Shabanali Hamzehnava Maryan 19a Informant's Name/Relationship (*Type, Print)* **Shabanali Hamzehnaya** <del>71i Hamzehnaza</del>/father item 27 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ott once. 1 X Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Pk 05/20/2012 21. Si maturi if Funeral Servi el Licensee MO1576 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Om Immediate Cause (Final Physician/ disease or condition resulting in death) Bone Marrow Failure Medical Due to (or as a consequence of) 3:03 Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 2012 that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical as the t IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Pnermonia Records, Completed Hamid 24a Was an certificate has **Division of Vital** Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: မ 1 X Inpatient 2 ER/Outpatient 3 DOA amzehnava, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: **X**Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier (Check 3 [ only one) 29b. Signature and title of certifie 29c. License number D22775

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 1 per doc, 17,18 per inf g928 6-12-12 SM
State of Maryland? Department of Health and Mental Hygiene

1- State amend item 19a per inf g928 6-12-12 vt
Registrar

Reg. No. 2 1 2

Reg. No. 2

3 Time of Death

2. Date of Death

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		4	For State		State	of Maryl	and / Dep	artmer <i>rtificat</i>			and iv	ientai H	ygiene	•		0 0 /	^
			Registrar  1. Decedent's Name	e (First, Middle, La	ast)		Ce	lincal	e or D	eatri		2. Date of D	Reg. No leath	201	21	3. Time of Death	力
	Physicia Medic		Bever1y	Ann		Harmo	on					Month	14, Da	2012 Yes	ar	11:45 ам	
	Examin		4a. Facility Name (if			,	1.16	1		Location o			40	. County of D			١
1			4450 Sou 5. Social Security No		Avenue,		rs. last birthday)		nevy er 1 Year	Chas		8. Date of B	irth	Montg 9		ry ace (State or Foreign	$\dashv$
	Funeral Director		509-24-6		1 □ M 2 □ XF		Yrs.	Months		Hours	Min.	(Month, E	Day, Year)		Countr	y)	
			Usual Residence	of Decedent		81						Aug. 1	8, 19	30		isas	4
	yland f sho	ctor	10a. State	10b. County		10c.	City, Town or Lo								10	d. Inside City Limits  1 ☐ Yes 2 ☑ No	
	e Mar	Director	MD 10e. Street and Nun		tgomery		Chevy		p Code				100 0	itizen of What	Count		$\dashv$
	ith th	ral		ıth Park	Arronno	Ant	416	101. 21	208	215				JSA	Count	y:	
	ems a	Funeral	11. Marital Status	ILII FAIK	12. Was Dec	edent Ever in		Was Dece			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - A			┨
3	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  4 Health and Mental Hygiene.  5 Health and Mental Hygiene.  6 Health and Mental Hygiene.  6 Health and Mental Hygiene.  6 Health and Mental Hygiene.  7 Health and Mental Hygiene.	ρ		ied 2 🗔 Married	Armed Fo 1 ☐ Yes If Yes, Gir	2 No		If Yes, spe 1 ☐ Yes				Rican, etc.)		Black, W Specify: B	/hite, et Lack	c.	
5	aturai	Completed	3 🗌 Widowed	4 ☐ Divorced 15. Decedent's	Year or D		16a Dece	dent's Usu	ial Occupa	ation			16b	Kind of Busine			Н
2	72 h	d m	(Spe	cify only highest of	grade completed		(Give	kind of wo	ork done d	uring mos	t of worki	ing	100.7	Ciria Oi Basiin	555/IIIQ	uou y	Ĩ
7	within giene.		Elementary/Sect	ondary (U-12)	College (*	5+	Pr	ncip	al _				Edu	cation	1		_
2	tai Hy d oth	To Be	17. Father's Name (						l	18. Moth	er's Nam	e (First, Middl	e, Maiden	Surname)			
<u> </u>	uld be I Men narke natic		Russell 19a. Informant's Na	McKinle		Huchan	d					A. Gr					$\dashv$
<u> </u>	2 sho th and 77 is r traun			ame/Helationship Layton Ha				-						r Town, State		4D 20815	
ָנ ע	I Heal		20a. Method of Disp		armon, c		b. Place of Disp	osition (Na	me of			Date		ocation - Cit			٦
2	age ento nt: If ry or			☐ Cremation 3 5 ☐ Other (Spe			cemetery, cre ate of Ho	•	-	i	May	23, 2012	Sil	ver Sp	rin	g, MD	
	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Fu			0					<sup>y</sup> ins	Fuṇera				, MD 2090	$\Box$
_	00 E 8 9		23a, Part 1. Exter 1	Bus	500	colo		-						er Spr			1
				rt failure. List only	one cause on e	ach line.							arrest,			Approximate Interval Between Onset and Death	
P	mysician/ Medical		disease or condition resulting in death)		_ a		Sequence of):	all (	Cell	Lung	Cano	er			+		$\dashv$
	Examiner		_				structi	ve Pu	ı1mon	ary I	)isea	ıse					
		iner	if any, leading to in cause. Enter Under	nmediate	Due to	(or as a con	sequence of):								Τ		
	and and transi	Examiner	Cause (Disease or that initiated event resulting in death)	injury is			rtery Di	sease	2						+		_
	cate be executed physician and s the burial transit	edical E	resulting in death)	Lasi		(01 43 4 001	ocquerioe oi).										
8	icate } j phys	ledic			d										_		$\exists$
8	anding use a	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, ou	atcome of pre	egnancy Fetal death 3	☐ Ectopic	: pregnanc	:v				23d. Date o		-	1
<b>X</b> 00	the atte	Completed by Physician/M	in the past 12 1 ☐ Yes 21 9 ☐ Unknown	K No		gnant at time		Other (					-	Month		Day Year	
į	at the ed by t detacl	M.	Part II. Other signi		contributing to	death but no	t resulting in the	underlying	cause giv	en in Parl	I.	23e. Die	d tobacco	use contribu	te to the	e cause of death?	
, L	uires th n signe uld be	iq pe	Diabetes	5								1 [	☐ Yes 2	2 □ No 3 l	☐ Prob	ably 4 🖾 Unknown	1
ecords,	as bee	plet										24a. W	as an topsy	prio	r to con	sy findings available npletion of cause of	
Ě	The la	Soll										pe	erformed? es 2 🔯 l	dear No 1		2 🗆 No	
	ician: sertific ector,	Be	25. Was case reference examiner?		Hospital: _				Oth	or:		k only one)					4
5	Physical direction	2	1  Yes 2	<b>☑</b> No	1 .	Inpatient :	2 ER/Outpati 28b. Time		28c. Injur	4 ⊔ №		ome 5 🔀 Re 28d. Describ		6 Other (S	Specify)		
פוכ	nding ath. :: After ie fune	icate	1 Anatural 2 Accident	5 Pending Investigat	(Mo	nth, Day, Yea	er) injury	М	work	Yes 2		Loui Dobbins		.,			
VISION	or Atter ter des irector n by th	Certificate:	3 Suicide 4 Homicide	6 Could no determine	28e. Plac	e of Injury - /	At home, farm, s	treet, facto	ry, office				n (Street a Town, Stat		r Rural	Route Number,	
5	spital o		29a. Certifier	1 🔣 Certifying P	hysician: To the	best of my k	nowledge, death	occurred	at the time	e, date an	d place, a	and due to the	cause(s)	and manner	as state	ed.	- 17
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death.  within 24 hours affer death.  completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check	2 ☐ Medical Exa 3 ☐ Certifying N	miner: On the ba	asis of examin	nation and/or inve	stigation, i	n my opinie	on, death o	occurred a	t the time, dat	e and plac	e, and due to	the cau	se(s) and manner state	ed.
			29b. Signature and	title of certifier	11 -	131			9c. Licens			0	29d. D	ate signed (M	4		
	10		1	Undr 1	plen	<u> </u>	(ltem 00-) T		101	1004	64	83		3/21	120	DIL.	_
			30. Name and add	cohen, M			(Item 23a) (Type) hady Gro		oad,	Rock	ville	e, MD	20850	)			
	Sta		31. Date filed (Mon		. 32.	Registrar's S	ignature /							·			
	Registra	ar	1 1	AT WW L	UIL LE	we	P. 7		4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19, 2<sup>Year</sup> Physician/ Month May P<sub>M</sub> 12:30 Esther Horner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Country) New York 099-05-1690 1 □ M 2 🔀 F 92 **Director** Sept. 21. 1919 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 8505 Springvale Rd. 20910 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Force ?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Sosin Jenny Balfour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Horner - Son 5219 Braywood Dr. Centreville, VA 20120 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State artment of I Burial 2 Cremation 3 Removal from State injury or King David Memorial Gardens 5/20/2012 Falls Church, VA 4 Donation 5 D ther (Specify) permit. | Departm Importa any inju ice Licensee 22. Name and Address of Facility National Funeral Home 7482 Lee Hwy., Falls Church, VA 22042 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Respiratory Failure Medical resulting in death) Due to (or as a consequence of) **Examiner** Pulmonary Edema Sequentially list conditions, if any, leading to immediate cause. Enter emberging Cause (Disease or injury Examine Due to (or as a consequence of) THE STATE OF that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) g 🖾 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: Parthin 24 hours after death. To the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month. Day. Year) D0068150 5/19/2012

Registrar
DHMH 17 Rev 06-2011

State

1500 Forest Glen Road; Silver Spring, MD 20910

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Siraj,

Nejib S.

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 20 Day 2012 4:30 P M Faina Immerman Medical 4a Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery 95 Rockville Dawson Ave. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** RUSSIA Month, Day, Ye Months 1 🗆 M 2 🕱 Director 216-37-1706 85 Usual Residence of Decedent 23a or 28a-f show ast be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD. MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral must 95 DAWSON AVE. APT. 512 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married 1 Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced WHITE is marked other than "natural aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 8 GROCERY MANAGER STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ ISRAEL **GUBERMAN** RIVA LISHANSKAYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 IMMERMAN/SON 16824 CENTERFIELD WAY, OLNEY, MD. 20832 MIKHAIL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-23-2012 COLUMBIA MEM. PARK CLARKSVILLE, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL
5801 CLEVELAND A 21. Signature of Funeral Service Licensee L HOME & CREMATORIUM, P.A. AVE., RIVERDALE, MD. 20737 HOUM M0091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death
3 YEARS Immediate Cause (Final disease or condition METASTATIC BREAST CANCER Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Pregnant at time of death Day Year detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det þ 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Tes 2 No Yes in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred After 1 work? 1 ☐ Yes 2 ☐ No 1X Natural 5 Pending Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff

To the Funeral Di

completed filled in Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) မ

State Registrar PAUL M. THAMBI, M.D. 6420 ROCKLEDGE DR., SUITE 4200, BETHESDA, MD. 20817
31. Date filed (Month, Day, Year)
NAY 22 2012

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0061083

MAY 21, 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 8092 Reg. No. 🗸 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2012 Month Virginia Carol Edwards Justice May 05:45 PM 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Ceci1 52 Willard Drive North East 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 2XXF Months Days Hours Min (Month, Day, Year, 69 Jan. 17. 1943 Elkton Maryland 220-62-3966 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2XXNo Maryland North East Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 52 Willard Drive 21901 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Was Deceden 2 Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Sullins Virginia Eller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willard Drive, North East, Maryland Daniel Justice / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer Cemetery Rising Sun, Maryland 22. Name and Address of Facility Crouch Funeral Home. P.A. 127 South Main Street, North East, Maryland 21901 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. Lift only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition as a consequence of): Brain Due to for as a consequence of C. \_

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

þ

Completed

Be

ပ္

21. Signat

Examiner

**Funeral** 

**Director** 

an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at

Hygiene.

filed

other

permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic evenone.

event, the

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Exami nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contrib þ Completed 25. Was case referred to medical Be examiner? Hos ၉ 1 Tes 27. Manner of Death Certificate: (Month, Day, Year) 5 Pending Accident Investigation Medical

JUI

Due to (or as a consequ	uence of):			
If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3 🗌 Ectopi	c pregnancy specify)		23d. Date of delivery Month Day Year
outing to death but not res	ulting in the underlying	g cause given in Part I.		o use contribute to the cause of death?
			24a. Was an autopsy performed 1  Yes 2	
		26. Place of Death (Che	ck only one)	
oital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	6 Other (Specify)
28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred

man St EHCKEr Md 21921

3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occur only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at	the time, date and place	e, and due to the cause(s) and manner stated
9b. Signature and title of certifier  The CLU USLL HD	29c. License number	29d. Dat	te signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )

State Registrar

223 aM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHIH HSU

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature

**OCME** 

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

May 28, 2012

State Registrar

I2-03530 Eric Murchison Jar			Black Indelible				jible.				
THE MUICHSON SAI	1- For State Registrar		d / Department Certificate		a Mental Hy	_	g. No.	2   809			
Physician Medical Examine	r ER	IC MURCHIS				2. Date of Deat Month May 7, 201	Day Year	3. Time of Death 1137 hrs			
	4a. Facility Name (if not institution 3800 Hawkins Point R		per)	4b. City, Town, or Baltimore	Location of Death		4c. County of Dea	th			
Funeral	Social <u>Security</u> Number		Age (In yrs. last birthday)			8. Date of Birt		irthplace (State or			
Director	UNK Usual Residence of Decedent	1 X M 2 F	M 2 F 58 Yr		s Hours Min.	08/28	/1953 Fore	ign ountryMARYLAND			
, any	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits			
Aaryland 28a-f show Latonce ector	MARYLAND			BALTIM		1 X Yes 2 No					
the Maryland is or 28a-f she tiffed at once Director	10e. Street and Number 1235 EAST	EAGER STRE	ET	10f. Zip Code	202	10	g. Citizen of What Co UNITED	•			
215-0036 be filed within 72 hours after death with the Maryland nal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.  Be Completed by Furneral Director	11. Marital Status	12. Was Deced	ent Ever in U.S. 13. V	Was Decedent of His	panic Origin? ( Spe	cify Yes or No-	14. Race - Ame	rican Indian, Black,			
er death with t	1 Never Married 2 Ma	1 Yes	es? 2X No	f Yes, specify Cuban,		Ricán, etc.)	White, etc.				
urs afte	3 Widowed 4 11 Dive	orced If Yes, Give Year or Dates: ify only highest grade of	completed) 16a. Deced	Yes 2 No lent's Usual Occupati		ork done	Specify: 15 16b. Kind of Business	BLACK siness/Industry			
6 n 72 ho an "na ical Ex	Elementary/Secondary (0-12)	College (1-4	or 5+) during	most of working life.	DO NOT use retire	ed)					
5-0036 led within 72 hour Hygiene. I other than "natur the Medical Exan	17. Father's Name (First, Middle,	Last)	TRANS	PORTATION	SUPERVIS			RANSPORTATIO			
21215 21215 Mental Hy marked o	JAMES A. JAMES				BEATRICE	MURCH	SON				
MD 212' d 2 should be the and Mental th and T is marke turnatic event	19a. Informant's Name/Relationsh MATYSHA JAMES						umber, City or Town, State, Zip Code)  ABERDEEN, MD 21001				
M 2 alth	20a. Method of Disposition	-	20b. Place of Disp	osition (Name of cerr		Date Date	20c. Location - City o				
MOF Pages nent of unt: If	1 Burial 2 X Cremation 4 Donation 5 Other Spi		y 05/	17/12	GLEN BURN	NIE, MD					
Baltimore, permit. Pages 1 ar Department of He Important: If ite Important: If ite injury or other tr	21. Signature of Funeral Service I		22	Name and Address	of Facility TT FUNERA	L HOME,	P.A. DE GRACE,				
Physician	23a. Part I. Enter the disease, or o	complications that caus	sed the death. Do not ente	552 LEWIS r the mode of dying, s	S STREET, such as cardiac or r	HAVRE respiratory arres	DE GRACE, st, shock, or heart	MD 21078 Approximate Interval			
/Medical Examiner	failure. List only one cause of Immediate Cause (Final disease		shot Wound of Head	I				Between Onset and Death			
	or condition resulting in death)	Due to (or as a co	nsequence of):								
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence of):					1			
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	risequence of):								
n and - tra	- INDENDED	d									
	IF FEMALE:	23c. If yes, outo	come of pregnancy				23d. Date of deliver	<u> </u>			
Box 68760, e death certificate be the attending physic of for use as the burn by sician/Med	23b. Was decedent pregnant in the past 12 months?	I I TIVE DILIL	at time of death	Fetal death 3	Ectopic pregnand	СУ		Day Year			
D. Box 68760, it the death certificate be e by the attending physicial school for use as the burial Physician/Media	1 Yes 2 No 9 Unkr	own 9 Unknown	3	Other (Specify)							
Ded det	1	ons contributing to de	eath but not resulting in the	underlying cause giv	ven in Part I.		acco use contribute to				
Records, P The law requires ficate has been sign page 2 should be o							24b. Were autopsy findings available				
of Vital Records, og Physician: The law requirement of the this certificate has been someral director, page 2 should har To Be Completed						autopsy perform 1 Yes 2	<u>ied</u> ? death?	completion of cause of			
	25. Was case referred to medical examiner?				of Death (Check on		No 1 ✓ Y	es 2 No			
of Vital Ing Physician: After this certifuneral director,	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa	njury 28b. Time o				esidence 6 🗸 Othe	r: Scene			
<b>-</b>	1 Natural 5 Pendi	ng FOUND: Da	y,Year) FOUND:			ubject shot	ow injury occurred self				
Division c spital or Attending tours after death, neral Director: Affilled in by the fun Certification:	3 ✓ Suicide 6 Could	igation May 7, 201: not be 28e. Place of	illding, etc. 28	8f. Location (Str		ural Route Number, City					
6 - 5 >	4 Homicide determ	(opeany) V				300 Hawkins I	Point Road, Baltimo	<u> </u>			
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic	(Check only		my knowledge, death occ xamination and/or investig								
E S H S	29b. Signature and title of certifier	-011	not	29c. License			29d. Date signed (Mo	nth, Day, Year)			
	30. Name and address of person v	who completed assess	f death (Item 22c)	O.C.M	1.E.		May 8, 2012				
	Victor Weedn MD JD	vno completed cause o Assistant Medic		W. Baltimore Str	reet, Baltimore	, MD 21223	3				
State	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature								

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20hate Per Mary 12928 56/25/1291120f Flealth and Mental Hygiene

			For State of	Cei	rtificate of Deati		Reg.	21112	18095				
	Physicia	n/	Decedent's Name (First, Middle, Last)     VIRGINIA EL.	I N	ate of Death tonth	Day Year	3. Time of Death						
	Medic Examin		4a. Facility Name (if not institution, give street and numb		4b. City, Town, or Location			23 2012 4c. County of Deatl					
April 1			166 CHERRY TREE LANE		ELK			CECIL					
	Funeral Director		5. Social Security Number 6. Sex 7 216-30-5784 1 □ M 2 🗓 F	. Age (In yrs. last birthday)  82 Yrs.	If Under 1 Year If Under 1 Months Days Hour	der 24 Hrs. 8. D. rs Min. (A	ate of Birth Month, Day, Yea B 19, 1	9. Birt Cou	hplace (State or Foreign untry)				
-			Usual Residence of Decedent			FE	В 19, 1	930	MARYLAND				
	ryland -f shc ied at	Director	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1   ✓ Yes 2   No				
	he Ma or 28a notif	Dire	MARYLAND CECIL  10e. Street and Number		ELKTON 10f. Zip Code		10a.	10g. Citizen of What Country?					
	with t s 23a iust be	Funeral	166 CHERRY TREE LANE		21921	1		UNITED STATES					
	death r item		11. Marital Status 12. Was Deced Armed Force		Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yeican, Puerto Rican,	es or No- , etc.)	14. Race - Amer Black, White					
036	s after ral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3  If Yes, Give Year or Date		1 ☐ Yes 2 🔀 No Spec	cify:			ACK				
2-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during n	nost of working	16b	. Kind of Business/	industry				
21215-0036	ithin 7; ene. • than he Me	Com	Elementary/Secondary (0-12) College (1-4	life. D	O NOT use retired) DUCTION WORK		EI	LECTRIC M	OTOR MFG				
d 2	iled will Hygik other	Be	17. Father's Name (First, Middle, Last)			other's Name (First							
ylar	ld be f Menta iarked atic ev	10	JAMES HENRY TERRELL		MII	LIE WARR	RICK						
Maryland	2 shouth and 17 is m	ig	19a. Informant's Name/Relationship (Type, Print)  LISA GARNETT / DAUGHTER	1	ng Address (Street and Nur CHERRY TREE								
re,	f Healt f Healt item 2 other		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	04/28/2	<u> </u>	. Location - City or					
OM.	Page ment o tant: If uny or		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place) MANOR CEM.	04/28/2		ESAPEAKE	CITY, MD				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licensee	22	2. Name and Address of Fa LISA SCOTT F 552 LEWIS ST	cility FUNERAL H	OME,P.A	١.					
			23a. Part 1. Enter the disease, or complications that ca	used the death. Do not ent				GRACE, M	MD 21078 Approximate				
4-	Phylician	9	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	Time.					Interval Between Onset and Death				
	Medical Examiner		resulting in death)  Due to (or as a consequence of):										
		Jer	Sequentially list conditions, if any, leading to immediate Due to (o	r as a consequence of):									
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events c.										
	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (o	r as a consequence of):									
3760	ficate be executed g physician and as the burial-transi	edic	d										
.89	ath certific attending p	Physician/Medical		ome of pregnancy irth 2 D Fetal death 3 D	Fotonio prognonov			23d. Date of del	ivery				
Box	Attending Physician: The law requires that the death certif ar death, are death.  ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	sicis	in the past 12 months?  1 ☐ Yes 2 ☐ No		Month Day Year								
P.0.	requires that the der been signed by the s should be detached	/ Phy	o use contribute to	the cause of death?									
S, F	uires the signeral si	Completed by					1 🗆 Yes	2 🗆 No 3 🗆 Pr	obably Unknown				
Sorc	iw requ	plet				2	24a. Was an autopsy		Were autopsy findings available prior to completion of cause of				
Rec	The law cate has page 2	Com					performed	? death?	2 🗆 No				
ital	sician: The certificate irector, pag	) Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:		_ Other	Death (Check only							
of V	Attending Physician: or death. ector. After this certific by the funeral director,	e: To	27. Manner of Death 28a. Date of		f 28c. Injury at	* 1	Residence Describe how in	6 Other (Speci jury occurred	fy)				
on	eath. or: Afti the fur	ficat	2 Accident Investigation	, Day, Year) injury	work?  M 1 ☐ Yes 2	2 □ No							
Division of Vital Records,	or Attending after death. Director: After I in by the fune	Certificat		f Injury - At home, farm, str g, etc. (Specify)	reet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Ω	To the Hospital or within 24 hours after To the Funeral Diracompletely filled in	Medical	29a. Certifier Certifying Physician: To the bes	st of my knowledge, death	occurred at the time, date a	and place, and due	e to the cause(s	and manner as sta	ated.				
	To the Ho within 24 To the Fu complete	Mec	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner:		, death occurred at the time,	, date and place, an							
	Viit O		29b. Signature and title of certifier	MD	29c. License number	719	29d.	Date signed (Month	, Day, Year)				
			30 Name and address of person who completed cause		Print)	UFI	14	100110					
	3		14. Chardon, M	A 253 G	ews luj	Havi	he o	la Oca	ce 2/0/8				
	Stat Registra		31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature	back				′				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Catherine Rhuie Jones Medical 4b. City, Town, or Location of Death Hagerstown 4a. Facility Name (if not institution, give street and number) County of Death Washington Examiner Meritus Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Social Security Number 7. Age (In vrs. last birthday) **Funeral** Clear Spring Hours 1/10/2199ay.1/19/1 8 94 220-42-5451 Director 1 □ M 2**X** F items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location the Maryland Completed by Funeral Director Clear Spring Washington 1 Yes 2 XNo 10g. Citizen of What Country? 10f. Zip Code 21722 14740 Mercersburg Road U.S.A Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status and Mental Hygiene.
and Mental Hygiene.
/ is marked other than "natural", or iten Black, White, et 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ribbon Mfg.co Flamentary/Secondary (0-12) packer College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Mae Trumpower 17. Father's Name (First, Middle, Last) James Oliver Faith ပ 19a. Informant's Name/Relationship (Type, Print)
Tean Bowers daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 10945 Big Pool Rd. Big Pool MD. 21711 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 20c. Location - City or Town, State
Clear Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5-30-2012 1 Burial 2 Cremation 3 Removal from State Mt. Tabor Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc Signature of Funeral Service Ucensee P.O.BOX 310 Clear Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on neet and Death Immediate Cause (Final Physician Medical disease or condition resulting in death) **Examiner** Sequentially list conditions, Examine If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? sate has 1 Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Impatient 2 I ER/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No Investigation Accident within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tith 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) non rus AAGERTON

DHMH 17 Rev 06-2011

State Registrar

				Please AMEND #26, PER MD	Type or Pri G929 7/17 State of M	i <b>nt in</b> /12 1 larylar	Black TRT id 7 Dep	<b>Indeli</b> l partme	ble Inlent of H	k. Ens lealth	sure A and M	II Copie Iental H	es Ar ygien	e Leg	jible.		
				1 - State Registrar Certificate of Death								Reg. No. 2012 18097					
				1. Decedent's Name (First, Middle, La		_			2. Date of D		to to	)/aau	3. Time of Death				
		Physicia Medio		Frederick Jone	es							Month 5	9	<sup>20</sup> 20	12	1:00 M	
		Examin		4a. Facility Name (if not institution, give				4b. Cit	y, Town, or	Location	of Death			-	of Death		
				25861 Quinton 5. Social Security Number 6. S			last birthday		rdela ler 1 Year		rinc	S 8. Date of B		icor	nico	place (State or Foreign	
		Funeral Director			X M 2 □ F 7.		Yrs.	Month		Hours	Min.	1 2 - 1 8	ay, Year	38_	9. Birth	place (State or Poreign htry)	
	7	show	ъ	10a. State 10b. County		10c, Ci	ty, Town or I	Location					-		10d. Inside City Limits		
	Anna	Ba-f s	Funeral Director	MD Dorches	ster	Ca	mbri	dae								1 🗆 Yes 2 🎞 No	
	A Od+	a or 2		10e. Street and Number		,			Zip Code				109. (	Citizen of	What Cou	ntry?	
	deiver	IS 23;	Jera	740 Foxtail Di	cive				1613				USA				
	400	ritem ner n	Ē	11. Marital Status	12. Was Decedent Armed Forces? 1 Yes 2		S. 13	3. Was Dec If Yes, sp	edent of Hi ecify Cuba	ispanic O ın, Mexica	rigin? (Spe an, Puerto l	cify Yes or No Rican, etc.)	)-		ce - Americ		
Mandand 01015_0036		ural", or	ted by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 🗌 Yes	2 🔀 No	Specif	y:			Specif	3lac	k				
7	5 3	"natu	plet	15. Decedent's E (Specify only highest gr			(Giv	cedent's Us ve kind of w	ork done c	during mo	st of worki	ng	16b.	Kind of B	lusiness In	dustry	
101	, i	than than the Me	Completed	Elementary/Seconday (0-12)	Elementary/Seconday (0-12) College (1-4 or 5+)					OO NOT use retired)							
7	3 3	Hygie other ent, t	Be (	17. Father's Name (First, Middle, Last)			IIIu	JK D	rive		her's Name	e (First, Middle		OSKi den Surname)			
2	3	be mertal lental rked tic ev	은	Emerson Sampso	on					Mar	v E.	Jone	s				
2	מו א	and M	"	19a. Informant's Name/Relationship (	_		19b. Ma	iling Addre	ss (Street a	and Numi	ber or Rura	l Route Numb	er, City	r, City or Town, State, Zip Code)			
		nd 2 salth a n 2 7 i		Catherine L. J	Jones/Wit	fe	740	Fox	tail	Dri	ve,	Cambr	idq	e, N	4D 2	1613	
Wica Baltimore,	5 7	of Her of Her fitem rothe		20a. Method of Disposition  1 X Burial 2 Cremation 3	•	20b. l	Place of Dis cemetery, cr	position (N rematory or	ame of r other plac	ce)		Date	20c.	Location	- City or To	own, State	
3 5		ment tant: jury o	l k	Donation 5 Other (Speci	fy)		omps	on To	own (	Cem	5-19	-2012	Ea	st 1	lew I	Market,MD	
3 5		permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee)  22. Name and Address of Facility 917 W. Isabella St.  Bennie Smith												•	
				Funeral Home Salisbury, MD 21801													
				shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	ie.	in, Do not e		,				arrest,			Approximate Interval Between Onset and Death	
3	P	nysician/ Medical		disease or condition resulting in death)	a. Ne	10	S te h	4	cuy,	Co	rucs				-		
	er.	Examiner			Due to or as	a conseq	uerice oi).										
9			лег	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):										
3	t d	id ansit	Examiner	Cause (Disease or linjury that initiated events  c.													
N	Pypolitac		I-I	resulting in death) Last	Due to (or as	a conseq	uence of):										
3, 6	Certificate be	hysic the bu	by Physician/Medica	d													
4		ding p	₩	IF FEMALE: 23c. If yes, outcome of pregnancy										201 Date of delivers			
, A	t d	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	25. If yes, or the first 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								23d. Date of delivery  Month Day Year				
	, d	y the	ıysi	1 Yes 2 No 9 Unknown	9 Unknown												
0	; ta	signed by the a	y P	Part II. Other significant conditions	ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobal								tobacco	acco use contribute to the cause of death?			
	i in	uld be	ed										1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐				
Š	2 2 3	s been si	Completed									24a. Wa	s an opsy	24b.	Were auto	psy findings available	
0	1 of 1	ne ha	ĕ									per	formed?		death?		
9		s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	W.				26. PI	ace of De	ath (Check				WW.e.	TER'S HOME	
3	hveic	this ce	은	1 🗆 Yes 2 🗔 No			ER/Outpat			4 🗆 1		me 5 E ne		6 X Oth	er (Specif	) HOTEL	
Š		After t	Certificate:	27. Manne Death  1 Natural 5 Pending	28a. Date of inji (Month, Da		28b. Time injury	/	28c. Injun work	?		28d. Describe	how inj	ury occuri	red		
	100	death tor: /	tific	2 Accident Investigation 3 Suicide 6 Could not I	De 290 Place of In	ium - At h	ome farm	M street facts		Yes 2	_	28f Location	/Street s	and Numb	er or Rura	I Route Number,	
Division of Vital Becords	7 6	s after		4 ☐ Homicide determined	building, et			street, racti	ory, office			City or To			er or nara	Thouse Namber,	
_	To the Hospital or Attending Division: The law requires that the death	to the mount of the withing trysterial intersection of the formal pirector. After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical Exam		examinatio	on and/or inv	estigation, i	in my opinio	on, death	occurred at	the time, date	and pla	ce, and du	ie to the ca	use(s) and manner stated	
	94	vithin o the	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	rse/Practioner: To the	e pest of fr	iy knowleage		9c. License		te and plac	e, and due to			ed (Month,		
4		7 - 0		▶ Vil		UN			0	47	924	1	5		. / -	12	
		10		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type			, ,					•		
_		51		NOMAN	THANK	4	50	73 /	sypa	35 5	C	TORR	10	hr"	11	0 21617	
		Sta Registr		31. Date filed (Month Day, Year) 20	112 32 Registr	rar's Signa	L A	bosse									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 e ar 16 8:00 **Physician** May рм Kalinowski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Marydel 4101 Barclay Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 3 9. Birthplace (State or Foreign 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Hours 1911 Dec Dolengi, Poland 100 Director 222-01-4752 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nont of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedien Experience must be notified at 1 ☐ Yes 2√ No Director New Castle New Castle DE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 19720 6 3rd Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Construction Electric Welder 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Kalinowski Alexander Kalinowski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4101 Barclay Road Marydel, MD Jo-Ann Murphy daughter 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Gracelawn
Memorial Park

20c. Location - City or Tox
20d. Location - City or Tox
20d. May 22,
2012

New Castle,
20d. Name and Address of Facility Gebhart Funeral Homes 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ⚠ Burial 2 ☐ Cremation 3 ☒ Removal from State New Castle, Delaware 4 ☐ Donation 5 ☐ Other (Specify) New Castle, DE 19720 531 Delaware Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has page 2 performed' 1 ☐Yes 2X No 26. Place of Death (Check only one) Taughter's residence funeral director, 25. Was case referred to medical Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director; A
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 17, 2012 D637-47 30. Name of address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Ukens, MD 2540 Centreville Road, Centreville, MD Jeffrey Ukens, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State	State of Maryla	nd / Depa	artment of H	lealth and N	Mental H	ygiene	3.0.0.			
	Registrar  Certificate of Death  Reg. No. 20   2										
Physician/ Medical	Evelyn Regina Ke	2. Date of D Month May 17	eath	Year	3. Time of Death 2:49 a						
Examiner	4a. Facility Name (if not institution, give College View Cer	street and number)		4b. City, Town, or I	Location of Death	Illay 17		ty of Death	2:49 a.		
Funeral	5. Social Security Number 6. Se			Freder				erick			
Director		7. Age (In yrs. 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi Aug 4,	rth		place (State or Foreig		
shov dat	10a. State 10b. County	10c. Cit	y, Town or Loc	ation							
he Maryland or 28a-f sho e notified at Director	Maryland Frederi		ederick					11	0d. Inside City Limits		
death with the items 23a or ler must be n	10e. Street and Number 2140 Collingwood	Lane		10f. Zip Code 21702			10g. Citizen of USA	What Count	1 ☑ Yes 2 ☐ N		
ter free by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give	Jf.	as Decedent of Hisp yes, specify Cuban, Yes 2 🔏 No	Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Ra	ce - America ck, White, et	tc.		
21215-003 vithin 72 hours at liene. In than "natural" the Medical Exa	15 Decedent's Ed	Year or Dates.	16a Decede	nt's I level Occupati			Specify				
thin 72 than than the Me	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give kir life. DO	nd of work done dur NOT use retired)	on ing most of workin	g	16b. Kind of E	lusiness Indu	ustry		
Id 2	17. Father's Name (First, Middle, Last)		Homema	ker			Own	Own home			
lan be fill ental rked ic eve	Paul Houck			1.	8. Mother's Name	(First, Middle,	Maiden Sumam				
ary hould and M s mai	19a. Informant's Name/Relationship (Typ	e Print)			Mabel B						
nd 2 sealth an 27 in rer tra	Kevin Kelly - son	-,	19b. Mailing 2140 Ca	Address (Street and ollingwoo	Number or Rural	Route Number	City or Town, S	State, Zip Co			
IOre	20a. Method of Disposition 1 🏿 Burial 2 □ Cremation 3 □ F	20b. Pla	ace of Dispositi	on (Name of		rreder			21702		
Baltimore, semit. Page 1 and separtment of Hee mportant: If item my injury or othe	4 Donation 5 Other (Specify)	Mt.	metery, cremat 01ive1	ory or other place)  Cemeter	1		20c. Location -				
Bal Bal Permi Depa Impo any ir	21. Signature of Funeral Service Licensee	01.		ame and Address o			Frederi Funeral		aryland		
	23a Part 1 Enter the discourse or account	Cleve	162	21 Opossu	mtorm Dil	- T	7	Mary:	land 21702		
Physician/	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):										
ed miner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequen	nce of):								
760 icate be executed physician and s the burial-transit edical Examiner	hat initiated events c. esulting in death) Last	Due to (or as a consequer	nce of):					+			
3760 filicate by g physic as the b	d.										
ox 68 ath certing at the certing for use or cian/A	FEMALE:  b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	If yes, outcome of pregnance  1 ☐ Live Birth 2 ☐ Fetal d  4 ☐ Pregnant at time of dea  9 ☐ Unknown	eath 3 🗆 Fc	topic pregnancy ner (specify)			23d. Date	of delivery	/ Year		
that the ned by the detach	art II. Other significant conditions contri										
Division of Vital Records, P.O. B the Hospital or Attending Physician: The law requires that the de hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the nipleted filled in by the funeral director, page 2 should be detached Medical Certificate: To Be Completed by Physic		bearing to death but not result	ng in the under	lying cause given in	Part I.	23e. Did toba	acco use contrib		ause of death?		
/ital Reco						24a. Was an	24b. We	ere autopsy f	indings available		
ifficate or, page 0, p	Was case referred to medical					autopsy perform	ed? de	or to comple ath? Yes 2	tion of cause of		
Physician: Physician: This certificatral director, print To Be C	examiner?	pital:			Death (Check onl			tes 2 L	I No		
Of Physical of Phy	Manne of Death	1 Inpatient 2 ER/ 28a. Date of injury 28t	Outpatient 3		X Nursing Home			Specify)			
Division of Valor Attending Physical or Attending Physical Control of the Funeral	2 Accident Superstigation	(Month, Day, Year)	injury	28c. Injury at work?		Describe how	injury occurred				
or Att	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				Location (Stron	et and Number o	5			
Dital pours a ceral D filled i	state)		te Number,								
	a. Certifier (Check 2 Medical Examiner: only one) 3 Certifying Nurse Pro	n: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.  On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
5 3 5 8	. Signature and title of certifier			29c. License numb	per	290	. Date signed (N	fonth, Day, Y	'ear)		
30	Name and address of any	10		12604	17	S	-17-17	>			
2 6	Name and address of person who complete Schamas 10	eted cause of death (Item 23a)	(Type, Print)	Heme	n Sha						
State 31.	Date filed (Month, Day, Year)	32. Registrar's Signature	81 1	rederi	uc 1	MD 2	1702				
Registrar	MAI & 1 2012	- Jensen B	. par	Ked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18° 2012 May PAUL WAYNE KENNEDY SR. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>FREDERICK MEMORIAL HOSPITAL</u> FREDERICK FREDERICK Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Months Hours 219-36-2936 **Director** 1 🛛 M 2 🗆 F 72 April 12, 1940 Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6832 Larkspur Square 21703 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner 01. þ 1 Never Married 2 M Married 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify: Specify.White Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usua (Give kind of woo life. DO NOT use permit. Page 1 and 2 should be filed within 72 h
Derartment of Health and Mental Hyglene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pipefi Be 17. Father's Name (First, Middle, Last) 2 Bernard Joseph Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres Lisa Kennedy / Wife 6832 Lark 20a. Method of Disposition 20b. Place of Disposition (Nar cemetery, crematory or c 1 Burial 2 XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Cre 21. Signature of Funeral Service Licensee Restha 9501 23a. Part 1. Enty the dise or complications that caused the death. Do not enter the mod shock, eart fail Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical P.O. Box 68760 as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic | 5 Other (se in the past 12 months?

1 Yes 2 No
9 Unknown Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying Completed by Records, page Hospital or Attending Physician: The I 24 hours after death, Funeral Director: After this certificate h stely filled in by the funeral director, page Division of Vital 25. Was case referred to medical Be 2 **2** No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 D 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory building, etc. (Specify) determined Medical Scertifying Physician: To the best of my knowledge, death occurred at 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in 3 Certifying Nurse Practitioner: To the best of my knowledge, death occ 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) つな omirant MO \$00 W

al Occupation rk done during most of working retired)	16b. Kind of Business/Industry
ter	Fire Protection
	irst, Middle, Maiden Surname) Elizabeth Kidd
	oute Number, City or Town, State, Zip Code) erick, MD 21703
ne of Date ther place) May 20,	, , ,
Address of Facility Yen Funeral Sen Atoctin Mountai	rvices, Skkot Cody P.A. in Hwy. Frederick, MD 21701
e of dying, such as cardiac or re	spiratory arrest, Approximate Interval Between Onset and Death
ecify)	23d. Date of delivery  Month Day Year
ause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Pres 2 No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1  Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
26. Place of Death (Check onl	
I	5 Residence 6 Other (Specify)  Describe how injury occurred
office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
ny opinion, death occurred at the	ue to the cause(s) and manner as stated. time, date and place, and due to the cause(s) and manner stated. and due to the cause(s) and manner as stated.
License number	29d. Date signed (Month, Day, Year)
, Frederick,	MD 2(70)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2X No

Maryland

11:49 A M

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month,

Day, Year)

32. Registrar's Signature

			Plea	se Type or							_	ible.			
		For State		State of	f Maryla		•	Health and	Mental Hy	/giene	0.0	1.0	1.0	101	
_		Registrar Certificate of Death								Reg. No	. Z U	14	1 6	<u> </u>	
Physiciar Medica		Peter	,	Krusen					Month	.O, Da	ž012	Year	4:5.	of Death	
Examine				give street and numb	ber)			, or Location of Deat		4c.	. County	of Death	1 400		
<i>!</i>		Holy Cro  5. Social Security N			7 4 (			Spring  ar   If Under 24 Hrs	Υ		Mo	ntgo			
Funeral Director		224-48-4		1 M 2 □ F	7. Age (In yrs.	Yrs.	Months Day					Birthplace (State or Fountry)			
MC.		Usual Residence			83				Sept. 1	18, 19	928		Danzig		
ryland I-f show ied at	5	10a. State	10b. County			ity, Town or						1		City Limits  es 2 X No	
he Ma or 28a notif		MD 10e. Street and Nun		gomery	81	lver	Spring 10f. Zip Code	3		10a Cit	tizen of W	/hat Cour		es Z KA NO	
with t s 23a ust be	Funeral Director	10804	Inwood	Avenue			2090			US		Truc Oos	,		
death items	ᆵ	11. Marital Status		12. Was Deced	lent Ever in U	J.S. 1:	3. Was Decedent o	f Hispanic Origin? (S ıban, Mexican, Puert	pecify Yes or No o Rican, etc.)		14. Race		an Indian,		
al", or	d by	1 ☐ Never Marr 3 ☐ Widowed		ied Armed Forming Armed Forming Armed Armed Forming Armed			1 ☐ Yes 2 🔀					ck, White, etc. White			
hours matur dical 6	Completed		15. Deceder	nt's Education	es.		cedent's Usual Occ			16b. K	and of Bu	siness/In	dustry		
hin 72 ne. <b>than</b> "	Ē	Elementary/Seco		st grade completed) College (1-	4 or 5+)	life.	DO NOT use retire	,	rking						
ed wit Hygie other ent, th	Bec	17. Father's Name (	First Middle I	ast) 4				n <b>inist</b> 18. Mother's Na	mo /Eirot Middle		ucat				
l be fill lental rked o	ᅙ	Bruno K		407					ig Olsh	•		,			
should and N is ma		19a. Informant's Na						et and Number or Ru	ıral Route Numb	er, City or	Town, St				
and 2 sealth		Friedel Z. Krusen/Wife 10804 Inwood Avenue, Silver Spring,M											D 20902		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.			X Cremation	3 🔀 Removal from S	State	cemetery, c	sposition (Name of rematory or other p		Date lay 25,				own, State		
nit. Parante portan injury		1													
Dep Imp			Jan		son ,	/	500 Unive	ersity Blv	d. W.,	Silve	me II er S	nc. prin	g,MD	20901	
		23a. Part 1. Enter t shock, or hear	he disease, or	complications that canny one cause on eac	aused the dea	ath. Do not e	nter the mode of d	ying, such as cardiac	or respiratory a	ırrest,			Approxim Interval B		
Physician/ Medical		Immediate Cause (		- a.	nary Ed								Onset and		
Examiner	resulting in death)  Due to (or as a consequence of):  End-Stage Renal Disease														
	l er	Sequentially list co	nmediate	b. Due to (or as a consequence of):											
e executed sian and cristiansit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury s	с	Due to (avec a consequence of)										
o la E	ᆱᅵ														
icate t	ed	d													
ending r use a	an/s	IF FEMALE: 23b. Was decedent		23c. If yes, outc			B   Ectopic pregna		23d. Date of c			ery			
death	Completed by Physician/Medic	in the past 12 in the past 12 in Yes 2 in Unknown	Month Day Year												
at the	Z.											bute to th	oute to the cause of death?		
n sign	g B	Diabetes Melltius, Type II									1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown				
w required by special strategies.	plet	COPD							24a. Wa						
The la ate ha	5 5							autopsy prior to completion of cau performed? death?  1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No					cause or		
ician: certific rector,	8	25. Was case referre examiner?		Hospital:				Place of Death (Che	ck only one)						
Phys r this eral dii	<u> </u>	1 Yes 2 2 27. Manner of Death				ER/Outpat	tient 3 L DDA		10me 5 Res				)		
ath. r: Afte	Icat	1 X Natural 2 ☐ Accident	5 Pendin Investig	9	n, Day, Year)	injun	/ W	ork? □ Yes 2 □ No	200. 20001120	now injury	, 0000110				
or Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could r determi	ined 28e. Place	of Injury - At h g, etc. (Speci		street, factory, offic	е	28f. Location (Street and Number or Rural Route Number, City or Town, State)					nber,	
pital o		29a. Certifier 1	Xcartifying	Physician: To the be	at of my least		h						- 1		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physipicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2	. ∟ Medical E	xaminer: On the basis Nurse Practitioner:	s of examinati	on and/or inv	estigation, in my op	inion, death occurred	at the time, date	and place	, and due	to the car	use(s) and n	nanner stated.	
Vithin Vithin Comp	٦	29b. Signature and						nse number	sides, and due to				Day, Year)		
10		1/200		m.J.				D66249		May 20, 2			2		
		30. Name and address Jonathan		who completed cause		, , , , ,		, Silver	Spring.	MD 2	20910	)			
State Registra	_	31. Date filed (Mont	h, Day, Year) Y 22 20		gistrar's Sign										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 21 Physician/ Melvin David Kaplan 201 7:08 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Calvert Port Republic 3315 First Street Social Security Number 6. Sex Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F March 31°, 1933 Washington DC **Director** 577-42-3214 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at **Funeral Director** Port Republic Maryland Calvert 28a-f 1 ☐ Yes 2 X No 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 23a or 3315 First Street 20676 or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces' rces / 2 □ No 54**-**56 Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Job Corp Educator construction educator Be Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Kaplan Elizabeth Wilson iff. Page 1 and 2 shours.

"If Health and Mr." To see 7 is mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie A. Kaplan - spouse 3315 First Street Port Republic MD 20676 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ← Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 05/29/2012 Cheltenham Marvland Signature of Funeral Service License 22. Name and Address of Facility BRau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rania disease or condition resulting in death) Medical Due t (or as a consequence of **Examiner** Gequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 1 | Yes 2 | 9 | Unknown the Hospital or Attending Physician; The law requires that the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{A}\) Residence 6 \(\sum \) Other (Specify) 2 ZNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier The dead Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Numer Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Numer Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johathan Lowenthal MD 110 HOspital Rd. Prince Frederick MD 20678 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 27, 2012 Year Physician/ 11:30 AM **Kight** Sr. Gordon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 100 Honeysuckle Lane Apt. 205 Frostburg Allegany 9. Birthplace (State or Foreign Country) MD Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 🗆 Dec 17:1933 Director 218-30-0034 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director "natural", or items 23a or 28a-f sledical Examiner must be notified MD Frostburg Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21532 USA 100 Honeysuckle Lane Apt. 205 permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🕍 No Specify If Yes, Give Specify. white 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Arrow Steel Fabrication machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lola E. Harper Lorraine Thomas Kight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 13318 Jade Street Cumberland 19a. Informant's Name/Relationship (Type, Print) ์MD 21502 Gordon Kight Jr. son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Scarpelli Funeral Home, P.A. 5/31/2012 MD Cresaptown Donation 5 D Other (Specify) of Funeral Service 22. Name and Carroellif Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nter the disease Approximate Interval Between Onset and Death shock r heart failure. List only one cause on each line Immediate Cause (Final Physician/ A-therosclerotic disease or condition resulting in death) 2 Veary Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has be lirector, page 2 s autopsy 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after dea. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hin 24 hours after the Funeral Diren mpleted filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, DO055324 2012

324

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month Warnetta C. Libby Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Calvert Memorial Hospital - 4th Floor Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🕱 F 96 0170171916 Yrs. Director 579-01-9667 Usual Residence of Decedent th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Calvert Prince Frederick 10e. Street and Number 85 Hospital Road. Room 123 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) ၉ Frank Himelright 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once. John W. Libby, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Amenda Mr. Ergler 23 art 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Atherosclerotic Physician/ disease or condition resulting in death) / Medical Examiner Hyper tensive Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by bowel obstruction Division of Vital Records, insulbiciency cate has page 2 s Consestive Heon FCH'lwre 25. Was case referred to medical examiner? 2 2 No 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Own Home 18. Mother's Name (First, Middle, Maiden Surname) Ethel G. Cantillon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2540 Cecil Lane, Huntingtown, MD 20639 20c. Location - City or Town, State 05/23/2012 | Brentwood, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 Approximate Interval Between Onset and Death (arch'o vous mor disease Carchiovos wlar disease 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining Prysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D-50653 5-18-2012 ayan-C. SURAWA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) church ton Road Deale m'D. 32. Registra s Signature

Reg. No. 2

2012

4c. County of Death

Calvert

10g. Citizen of What Country?

United States

16b. Kind of Business Industry

Specify:

14. Race - American Indian,

White

Black, White, etc.

11:00

9. Birthplace (State or Foreign

DC

10d. Inside City Limits

1 Yes 2 X No

Country)

ам

18<sup>3</sup>

drw State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

5851-

31. Date filed (Month, Day, Year)

Eyan.C.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. 1710 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OF BALTIMOR MARYLAND MED CTK Baltimore 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 150-24-3644 Director 1 🗆 M 2 04/07/19 New Jersey er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 No Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2578 Vance Drive U.S.A 21771 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed Forces? Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Officer Finance traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ဂ Edwin M. Ryan Georgia Hannah Covert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a if item 27 is Joseph Long III / Son 2578 Vance Dr. Mount Airy Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or once. 05/31/2012 4 Donation 5 Other (Specify) Arlington Nat. Cem Arlington, Virginia Signature of Funeral Service Acepsee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ POSTERIOR CEREBRALINETERY DISTRIBUTION disease or condition resulting in death) Medical Examiner LCORD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury and-trans that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending work? Accident Investigation 24 hours after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month. Day, Year, 21-2012 WY WESTY OF MESICAL CENTRE pleted cause of death (Item 23a) (Type, Print) ZVAGIND R FLOOR NEUROCARE BALTIMORE, MD 31201 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 21 Catherine Jane Longnecker 2012 2:40p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Healthcare Center Washington Hagerstown Social Security Number **Funeral** Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 217-28-5699 **Director** 1 🗆 M 2 🏝 F 02/16/1930 Pennsylvania 82 Usual Residence of Decedent 10a. State with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Maryland Hagerstown 1 X Yes 2 No Washington 10e. Street and Number ò 10f. Zip Code be r 10g, Citizen of What Country? ms 23a must be Funeral 21740 333 Mill Street U.S.A iral", or items 2 Examiner mus death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Bace - American Indian Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Yes 2 XNo 1 Yes 2 No Specify: If Yes, G "natural", Completed 3 № Widowed 4 □ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever ည Jacob Kerlin Viola Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Longnecker / Daughter 21027 Park Hall Rd Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 5/25/2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) Rest Haven Cemetery Sig Fe of Funeral Se de Licen 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician, Vascular Dementia Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hypertensive Heart Disease burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Dav Year Pregnant at time of death detached the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy perfor*m*ed? Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complete Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Madera Marce R125360 5/21/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Naden-Blucher, CRNP - 333 Mill St., Hagerstown, MD 21740 31. Date filed (Monti State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mau Dvoyra Litvinskaya 12:02pm 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8 Date of Birth **Funeral** Days Hours (Month, Day, Year) Min. 213-35-9828 Director 1 □ M 2 🔏 F 91 12/03/1920 Ukraine Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 10b. County 10c. City. Town or Location 10d. Inside City Limits Rockville Maryland 1 Yes 2 No Montaomeru 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Bldg B Funeral 14411 Traville Garden Circle. #210 20850 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Clothing Factory Be Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mordko Litvinsky Rosa Sitnitskaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vladimir Entin - Son 1305 Windleaf Drive, Unit P, Reston, VA 20194 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Judean Mem. Gardens 05/21/2012 Olney, Maryland Signature of F eral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician. Congestive Weart disease or condition Medical resulting in death) Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 05 Due to (or as a consequence of). and Due to (or as a consequence of): buria attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ☐ Pregnant at time of death ☐ Unknown 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) itvinska 2 X No 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29d. Date signed (Month, Day, Year) D68405 051 2012 9 lereralli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., David Guevara-Nieto, 8600 Old Georgetown Road, Bethesda, Maryland 20815 31, Date filed (Month, Day, Year) State MAY 22 2012 Registrar

10%

6

CZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Betty L. Lewis 19 2012 **A** M 1:30 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3200 N. Leisure World Blvd., Silver Spring If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Dav. Year) Hours 071-24-8200 Director 1 M 2 X F Jan. 28, 1932 New York 80 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 1 🗌 Yes 2 🗶 No Silver Spring MD Montgomery 10e. Street and Number 10g. Citizen of What Country? ö rms 23a or Funeral with: 20906 United States 3200 N. Leisure World Blvd., items permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.] Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leithold Selma Raskin Morris David 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Donald Lewis, spouse 3200 N. Leisure World Blvd. #405 Silver Spring. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) 5/21/2012 Olney, Maryland Judean Mem. Gardens 21. Signa ure of Funeral Service Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MU0709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ METASTATIC OVARIAN CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying as the burial transif Hospital or Attending Physician: The law equires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital R. cords, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the a q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 XNatural Accident
Suicide Investigation etely filled in by the 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cestifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, D35579 May 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Miller, 8218 Wisconsin Avenue, #305 Bethesda, MD

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

2 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03728 State of Maryland / Department of Health and Mental Hygiene Jack Whitfield Murphy 201 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 15, 2012 1500 hrs **Medical Examiner** Jack Whitfield Murphy Jr. 4b. City, Town, or Location of Death c. County of Death Facility Name (if not institution, give street and number) Doyle Anne Arundel 389 Deale Harbour Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 214-48-9770 Sept.19, 1947 Country)Maryland 64 1X M 2 F Usual Residence of Deceden 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location 1 Yes 2 No PA Schuykill Orwigsburg Pages 1 and 2 should be filed within 72 hours after death with the Maryland thealth and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 1102 Village Road 17961 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Funeral 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 1X Yes White If Yes, Give Year Vietnam 1 Yes 2 No specify: Specify: 3 Widowed 4 X Divorced ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Landscape Manager Landscaping 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Olausen Jack Whitfield Murphy, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) tant: If item 27 is m Bealls Farm Rd., Frederick, MD Scott Murphy / Son 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition ltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 5/18/2012 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the dise **Physician** Between Onset and failure. List only one cause on each line nviedicai a Neck Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed death? 2 No ✓ Yes 2 No 1 Yes this certificate 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury Fell down hatch steps on sailboat May 15, 2012 1 Natural 1420 hrs 1 Yes 2 ✔ No Director: Pending death. 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 6 Could not be or Town, State Chesapeake Bay near Rock Hold Creek, , Md. determined (Specify) Boat Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2012 du 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

		Please	e Type or Prir					-		_	ble.		
		For State	State of Ma	arylan		artment of F		√lental Hy	/gien	е			
		Registrar  1. Decedent's Name (First, Middle, La	pet)		Ce	rtificate of L	Death	Ta 2 : 12	Reg. N	0.20	12	18	
Physicia			·					2. Date of De May 21,		ay	Year	3. Time of 12:01	Death p M
Medic Examin		Barbara B. Merr  4a. Facility Name (if not institution, giv			-	4b. City, Town, or	Location of Death			c. County o	f Death	12.01	P
A		8220 Fairground R	d.			La	Plata			Char			
Funeral				(In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da	rth a <i>y, Y</i> ea <i>r)</i>		9. Birthp Count	lace (State o	r Foreign
Director		220-36-6462 Usual Residence of Decedent	1 □ M 2 🔀 F   72	2	Yrs.			08-24-	1939		Mary	land	
/land f shov	tor	10a. State 10b. County			y, Town or Lo						1	0d. Inside Ci	ty Limits
e Mar r 28a- notifie	Jire	MD Charl	es		LaPlat								2 X No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<b>Funeral Director</b>	10e. Street and Number 8220 Fairground R	d.			10f. Zip Code 206	46		10g. C	itizen of WI USA		iry?	
eath v tems er mu	Fune	11. Marital Status	12. Was Decedent Ev	er in U.S	3. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No	-	14. Race		an Indian,	
ifter d ", or i	by	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔀 N If Yes, Give	No		If Yes, specify Cuba  1 Yes 2 No		Rican, etc.)			White, e	tc.	
ours a atural	Completed	3 Widowed 4 Divorced	Year or Dates.								Whit		
.: an "na Medic	mpl	(Specify only highest g	rade completed)	,	(Give	dent's Usual Occup kind of work done o OO NOT use retired)		ring	16b.	Kind of Bus	iness/Inc	ustry	
withir giene rer th		Elementary/Secondary (0-12)	College (1-4 or 5-	-)	P	rincipal			E	ducat	ion		
e filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam						
d Mer mark matic		C. Paul Barnhart  19a. Informant's Name/Relationship (	Tree Briefs				Henriett						
12 should an alth an 27 is r trau		Roger B. Merrick				ng Address (Street a						· ·	
1 and of Hea of item other		20a. Method of Disposition		20b. P	lace of Dispo	osition (Name of		Date		Location - C			
Page ment ant: II ury or		1 Burial 2 X Cremation 3 4 Donation 5 Other (Spec	☐ Removal from State ify)			matory or other plac $1 ext{d-Echols}$	1	5-2012	Cha	rlott	е На	.11, M	D
permit. Depart Import any inj		21. Signature of Funeral Service Licen	1 1			2. Name and Addres							
40 = 60		23a. Part 1. Enter the disease, or con		10094		.O. Box 5				546			
Dhysisian/		shock, or heart failure. List only	one cause on each line.	une death	i. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,			Approximate Interval Bet Onset and I	ween
Physician/ Medical		disease or condition resulting in death)	a. Due to (or as a	consequ	lence of):	- 91	Cur	7			+		
Examiner	_	Sequentially list conditions,	b. ——										
p its	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ience of):								
e executed ian and urial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequ	ience of):								
be ex sician buria			d										
or Attending Physician: The law requires that the death certificate be after death.  Director, After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE:	- 0.						Т				
eath certifica attending pl	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Feta	death 3	Ectopic pregnanc	су			23d. Date			
e deal the at thed f	ysic	1 Yes 2 No	4 Pregnant at 9 Unknown	time of d	leath 5 L	Other (specify)				Mont	h	Day Y	/ear
requires that the death been signed by the atte should be detached for	by Ph	Part II. Other significant conditions	contributing to death bu	t not res	ulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contrib	ute to the	e cause of de	eath?
luires in sign	ed b					<u> </u>		1 🗆	Yes 2	□ No 3	4 Prob	ably 4 🗆 l	Unknown
aw rec as bee	Completed							24a. Was				sy findings a	
The law cate has page 2 :	Com								ormed?		ath?		2030 01
ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Chec	k only one)	- (				
Physer this eral di	e: 10	1 Yes 2 No 27. Manner of Death	1 Inpatie		ER/Outpatie 28b. Time o	nt 3 🗆 DOA	4 L Nursing Ho	ome 5 Resi			(Specify)		
inding ath. r: Afte	icat	1 Accident Investigation	(Month, Day,	Year)	injury	work		200. Describe	now mja	ry occurred			
r Atte ter de irecto n by ti	Certificate:	3 Suicide 6 Could not I 4 Homicide determined				reet, factory, office		28f. Location (			or Rural	Route Numb	er,
pital o													
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 \(\sumeq\) Medical Exam	ysician: To the best of m niner: On the basis of ex- rse Practitioner: To the	amination	n and/or inves	stigation, in my opinio	n, death occurred a	t the time, date	and plac	e, and due t	o the cau	se(s) and mai	nner stated.
To the comp	2	29b. Signature and title of certifier	10	Dest Of II	ly knowledge	00- 1:	a constant	ace, and due to		ate signed (			
. 0.		> KMC	ell-			PD	835	)	S	, ->	· G-	-()	
m		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, I	Print)   - f	835 16th	1	Λ	1 0	11	01.	
Stat	e	31. Date filed (Month, Day, Year)  MAY 2 3 20	37 Registrar	's Signat	ure		1000		ر	5	-0'	U	
Registra	r	MAY 2320	12 ama	1	. pa	well							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leslie Allison Taylor Mong 8:30 A M 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 665 Genessee Street Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 215-74-0417 54 Director 1 □ M 2XXF April 29, 1958 Pennsylvania 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Maryland Anne Arundel Annapolis TXYes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò must be r Funeral 665 Genessee Street 21401 U.S.A. items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 XXIIIo Specify: Specify 3 Widowed 4 Divorced Completed al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Production Manager Publications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Willis Taylor မ Alice Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Taylor/mother 21401 1713 Lindamoor Lane Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/21/2012 Glen Burnie, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Immediate Cause (Final ⊇nset and Death Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope has page 2 24 hours after death.

Funeral Director. After this certificate 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ပ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. No ner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗀 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifie 🗅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 21,2012 May address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Signatur

MAY 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ JoAnn Marie Markle Mav 22 8:15 p.m. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 44492 Clarkes Landing Road St. Mary's Hollywood If Under Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours Director 198-28-3224 1 M 2 🛚 F 75 Pennsylvania Usual Residence of Decede 02/06/1937 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 🗓 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? the Medical Examiner must be Funeral with 23a 44492 Clarkes Landing Road 20636 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Civil Service 10 Bartender and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Charles Becker Helen Hockensmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Smith/Daughter 44492 Clarkes Landing Road, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 05/23/2012 Charlotte Hall, MD Stillhature, dr/Funer | Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Michele Brinsfield M01652 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final thiemers Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine hrive or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths?

1 Yes 2 No
9 Unknown Pregnant at time of death be detached Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □ Unknown Completed 1 Yes 2 No should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn certificate 1 ☐ Yes 2 ☐ No Yes funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State, To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knee edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle of certifier 24 2 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

(G) Ruma

State

Kimberly

DHMH 17 Rev 06-2011

4435 Mervell Dean Road, Hollywood, MD

20636

CRNP

Codk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 4c. County of Death Baltimore Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Month, Day, Year)
July 3,1947 222-32-2111 Director 64 1**X** M 2 □ F Delaware il Hyglene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examirer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No New Castle Wilmington 10e. Street and Number 10g. Citizen of What Country? Funeral 2803 Bexley Court 19808 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 □ No within 72 hours efter Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Investigator self-employed 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **James McCloskey** Evelyn Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health er Important: if item 27 is Pamela McCloskey (wife) 2803 Bexley Court Wilmington, DE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ò 1 Burial 2 Cremation 3 Removal from State Delaware Veterans 4 ☐ Donation 5 ☐ Other (Specify) May 22, 2012 Bear, DE Memorial Cemeter 21. Signature of Funeral Se 2 Name and Address of Facility
McCrery & Harra Funeral Homes & Crematory, Inc. 3924 Concord Pike Wilmington, DE 19803 23a. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ase or condition REUMONIO Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the deeth certificate be executed es been signed by the ettending physicien end 2 should be deteched for use es the burlei-trensit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 4 Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, Pancy to per 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificete hes prior to death? perform 1 Yes 2 No burs after death. eral Director: After this certific filled in by the funerel director. 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Other: 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mannes of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending Division 1 Yes 2 No Investigation 3 D Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital of 24 hours at Funeral D Medical 29a. Certifier 1 VCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri lathan 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. L Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1:00 PM 2012 Barbara Ann Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Haspital Regional Laurel George's -durel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 577 58 2819 Usual Residence of Decedent **Director** 1 □ M 2 🕅 F 70 May 10, 1942 Louisiana "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 XNo Silver Maryland Montgomery Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 13856 Turnmore Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Never Married 2 🛱 Married by 1 Yes 2 No If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. **Black** 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Dept of State Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Rav Leila Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8717 Deborah Street, Clinton, MD 20735 Debra Martin (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery May 18, 2012 4 Donation 5 Other (Specify) Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria ore of Funeral S rvice Licensee Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 6 months Metastatic ymphosarcomd disease or condition Medical resulting in death) **Examiner** week Sequentially list conditions, ne cause. Enter Underlying Cause (Disease or injury that initiated events Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 Unknown signed by the a d be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chest Wall Abscess 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmonary Disease 24a. Was an autopsy performed? Yes 2 No certificate has Coronary Artery
25. Was case referred o medical Disease 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 N Inpatient 2 ER/Outpatient 3 E within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0.0057216 Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7360 Van Dusen Baako. aurel Regional M.D Michael

State Registrar

4			For State	Please	State of		d / Dep	artment	of H	lealth			/gien	e	ible.	1.0	115
20			Registrar	e (First, Middle, La	not)		Cei	tificate	ot L	eath		0.0.4.60	Reg. N	o/ U	16	10	113
03:20A	Physicia			C. McMic	,							2. Date of Do	14 <sup>D</sup>	ay 20	$1^{\frac{Y_{ear}}{2}}$	3. Time of	f Death  5 A M
0	Medic Examin		4a. Facility Name (if			r)		4b. City, To	wn, or	Location	of Death			c. County		1 3:1	5 A
12			Upper Ch	esapeake	Hospital			Be:	1 A	ir				Har	ford		
114/20/	Funeral		5. Social Security N			Age (In yrs. I	ast birthday)	If Under 1 Months [	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi			9. Birthp	lace (State c	or Foreign
ý. <b>–</b>	Director		210-12-9 Usual Residence		1 □ M 2 🛣 F	87	Yrs.					9/21/	1924		$P^{A}$	1	
150 aca	show d at	for	10a. State	10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside Ci	ity Limits
0	Mary 28a-f otifie	Funeral Director	MD	Harfo	rd	Ве	elcamp									1 🗆 Yes	2 <b>K</b> No
20	th the	밀	10e. Street and Nur	mber				10f. Zip Co	ode				10g. C	Citizen of \	What Coun	try?	
(7	ath wil	nue	1123 Be1	camp Gar	th 12. Was Decede	at Ever in 119	2 112		101		ain? (Cna	oify Van ar Na	US		A	1 - P	
of F	or ite	by Fi		ried 2 Married	Armed Force	s?	3.	f Yes, specify	Cuba	n, Mexicar	n, Puerto	cify Yes or No Rican, etc.)			e - Americ k, White, e	etc.	
1924	ırs aftı ıral", IExar	ed t	3 X Widowed	4 Divorced	If Yes, Give Year or Dates			I ☐ Yes 2 🛭	<b>X</b> No	Specify:				Specify:	Whi	.te	
5-0	2 hou "natu adical	Completed	(Spe	15. Decedent's lecify only highest g	ducation rade completed)		(Give	dent's Usual C kind of work o	done a		t of worki	ng	16b.	Kind of B	usiness/Ind	lustry	
12/	thin 7 sne. than he Me	E	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)	life. D	O NOT use re	tired)	Ü			\ <sub>1.1</sub>	. # a h	Manuel		4
00 100	ed wi Hygie other ent, tl	Be (	10 17. Father's Name (				] Jew	eler		18. Moth	er's Name	e (First, Middle				actur	ing
an	l be fil lental rked tic ev	욘	James L.	Nolan								Schwar			-7		
PoB = 0q/21 Maryland/2121	should and N is ma		19a. Informant's Na		Type, Print)		19b. Maili	ng Address (S	treet a			l Route Numb		or Town, S	tate, Zip C	ode)	
Ø ∑	nd 2 s ealth m 27				- daught					ngo F	Road,	Bel A	ir,	MD 2	1014		
· 642 Baltimore,	ge 1 au t of H <b>if ite</b> or oth		20a. Method of Disp 1 X Burial 2		Removal from St		Place of Dispo emetery, crea	sition (Name a	of er plac	e)	Ε	Date	20c. l	Location -	City or To	wn, State	
ti 🛠	t. Pag rtmen rtant:			5 Other (Spec		Lau		11 Cem							oia,		
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	ner Licer	isee							T.Foar , Risi				-	
<i>60464</i> ■ Balti		Н	23a. Part 1. Enter	the disease, or con	nplications that cau	sed the deat								, ,	1110 21	Approximat	te
00	'Invoicion/		Immediate Cause (	(Final	ne cause on each	70.7	n	14000	21/	la a	0	nfar	nf.	ion	,	Interval Bet Onset and I	
2	Medical		disease or condition resulting in death)	on .	a. Due to (or	as a consequ		700				-gar		, , ,	-		
7	Examiner	Ļ.	Sequentially list co	enditions.	b. ————							-1					
W	sit q	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or	nmediate riving	Due to (or	as a Consequ	derice of.										
#	e executed cian and ourial-transit	Exa	that initiated event resulting in death)	s	C. Due to (or	as a consequ	uence of):								_		
	be ex sician			·	d												
<i>M</i>	eath certificate be attending physici i for use as the bu	Physician/Medical	IF FEMALE:		- u.												
ربر × نور ×	h cert tendir or use	an/I	23b. Was decedent in the past 12		23c. If yes, outcor	ne of pregna th 2  Feta	incy al death 3 [	Ectopic pre	gnanc	у					te of delive	*	
Poc	deat the at hed fo	/sici	1 Yes 2 D	No	4 🗌 Pregnar 9 🗌 Unknow		death 5	Other (spec	ify)	-				Мо	nth	Day `	Year
0.0	es that the dea signed by the a I be detached f		Part II. Other signif		contributing to deat	h but not res	ulting in the u	nderlying cau	ıse giv	en in Part	1.	23e. Did	tobacco	use conti	ibute to th	e cause of d	leath?
S, F	ires the signer of the signer	d by		Deme.	rtia							1 🗆	Yes 2	No	3 🗌 Prob	ably 4 🗆	Unknown
ecord	v require s been si should	Completed										24a. Was		24b. \	Nere autop	sy findings a	available
e/ Rec	he lav te has age 2	Juo	-									auto perf 1  Yes	ormed?	/ 3	orior to cor death? 1 □ Yes	npletion of c	ause of
Ag (	vysician: The law is certificate has the director, page 2 s	Be C	25. Was case referre	ed to medical	,			2	26. Pla	ace of Dea	th <i>(Ch</i> e <i>ck</i>		2 1	NO	I LI TES	2 LI NO	
Z ¥	Physic this ce al dired	은	1 🗆 Yes 2 🛭					t 3 🗆 DOA	Othe	er: 4 🗆 Nu	ursing Ho	me 5 🗆 Res	idence	6 🗆 Othe	er (Specify)		
ا ر ۱ of	ing P	ate:	27. Manner of Deatl  1 Natural	5 Pending		njury Da <i>y, Y</i> ea <i>r)</i>	28b. Time of injury	200.	. Injury work	?		28d. Describe	how inju	ry occurre	∍d		
em ision	ttend death stor: / y the	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not	oe Dlago of	Injuny - At ho	me farm etr	M		Yes 2 🗌		28f. Location	Ctroot o	nd Numbe	or Or Dural	Douto Numi	201
$\mathcal{N}ein$ Division	I or A after Direct d in b		4  Homicide	determined	building,	etc. (Specify	) )	oct, ractory, o	THEE			City or To			si Ui nuiai	noute Numi	jer,
20	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death of the this certificate has been signed by the attending physici To the thereator. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	29a. Certifier 1		/sician: To the best												
	the Hi thin 24 the Fi	Me	only one) - 3	_ Certifying Nu	niner: On the basis of the Frantitioner: T	or examination	n and/or inves	Seat! Jodina	ed at ti	ethre, Ja	courred at	the time, date	and plac	e, and due	e to the cau	se(s) and ma	inner stated.
	North Con		29b. Signature and	title of certifier	)			29c. Li	icense	number	6-	partir.	29d. D	ate signed	d (Month, E	1	- (3
			00 Norm	MW.O		£ -1	00-1/7		103	1590	کدر		n	lay	18	7h, 2	012
	5		30. Name and addit	mo person who	completed cause of	LU:DI		hesa	DO	ake		()r 1	30/	Air	- M	102/0	014
	Stat		31. Date fil- (Mont	h, Year)	32. Regi	strar' Si nat		and the same	-			- 1	- 1		N.		
	Registra	ar		MUI	BO AT	assur.	14. 19										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CORNELIUS WILLIAM MCLAIN, JR 12:13 AM 2012 Medical Lock 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR **HARFORD** 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Min **Director** 215-58-1801 1 X M 2 🗆 F 59 Vrs APRIL 7, 1953 MARYLAND Usual Residence of Decedent or 28a-f shov 10a. State notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 😾 No MARYLAND HARFORD STREET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a o or other traumatic event, the Medical Examiner must be by Funeral 1525 ARENA ROAD 21154 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates. 1971-73 15. Decedent's Education (Specify only highest grade completed) 5-17-12-71/10013 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LANDSCAPER 12 LAWN SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CORNELIUS WILLIAM MCLAIN ERNESTINE DIVERS MADDOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health a TIQUILA PRICE-SIMPSON/DAUGHTER 5726 LOUISIANA ST., CAMP LEJEUNE, NC 28547 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) ST. JAMES UAME CEM 5/22/12 DARLINGTON, MD 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P
552 LEWIS STREET, HAVRE DE 21. Signature of Funeral Service Licensee Both GRACE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ISC disease or condition resulting in death) Medical Due to (or a te consequence of) 3 **Examiner** 75E0000W Sementially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cornelius 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 Jas 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending McLAin, Investigation 1 Yes 2 No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 29a. Certifier (Check only one) 29c. License number 0 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1414A State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Item 2	State of Marylar <b>6 per verb.</b> ,	nd / Depa <b>g928, 0</b>	rtment of H <b>6/08/201</b> filicate of L	lealth and 2dhb Death	Mental Hy	giene	2012	18117
			Decedent's Name (First, Middle, Last)		007	imouto or b	· outir	2. Date of De	-	UIC	3. Time of Death
	Physicia Medio		J05hua		<u> </u>	oore		Month	1 30	2012	11.37p M
)	Examin	er	4a. Facility Name (if not institution, give str	4.4	1-01	4b. City, Town, or	0	h	4c. (	County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	TQ   last birthday)	If Under 1 Year	nore C		th		slace (State or Foreign
	Director			M 2 □ F 24	Yrs.	Months Days	Hours Min.	July 10		7 Ma	ryland
	and show	ō	Usual Residence of Decedent  10a. State 10b. County		ty, Town or Loc	ation		J Gary It	, 150		0d. Inside City Limits
	Maryla 28a-f	rect	Maryland Cecil		E1kton						1 🗆 Yes 2 🗓 No
	th the	al D	10e. Street and Number			10f. Zip Code				ren of What Coun	•
	ems 2	<b>Funeral Director</b>	212 Bluegrass Driv	. Was Decedent Ever in U.	s. 13. v	21921 Vas Decedent of His		pecify Yes or No-		4. Race - America	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", in item 27 is marked other than "natural".	by	1 🗓 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 No 1 Yes 2 No If Yes, Give Year or Dates.	l1	Yes, specify Cubar  ☐ Yes 2 🗓 No	n, Mexican, Puerl	to Rićan, etc.)		Black, White, e	etc.
15-0	72 hou "natu edical	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	(Give I	ent's Usual Occupa ind of work done d		rking	16b. Kin	d of Business/Inc	lustry
712	vithin 7 iene.	Соп	Elementary/Secondary (0-12)	College (1-4 or 5+)	Co	NOT use retired)  ok			F	Restaura	nt
pu	filed val Hygal Hygal of othe	Be (	17. Father's Name (First, Middle, Last)	-				me (First, Middle,		urname)	
yla	uld be Ment narke	To	David Brian Erdner					ne Moore			
Maryland	2 shot Ith and 27 is n traum		19a. Informant's Name/Relationship (Type, David B. Erdner/Fa			g Address (Street a Augustin					
			20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		ne 4,		cation - City or To	
Baltimore,	Page 1		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	1 011	thodis	atory or other place III L Cemeter	v 201	12		Cherry Hi	
Ball	permit. Page Department of Important: If any injury or once.	10	21. Signature of Funeral Service Licensee	0	22	Name and Addres				Funeral	ls, P.A. 21921
			23a. Part 1. Enter the disease, or complication		h. Do not ente					LOII, PID	Approximate
N.	hysician/		shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ause on each line.	no sis						Interval Between Onset and Death
1	Medical Examiner		resulting in death) a.	Due to (or as a consequ	uence of):	0					
	WEST.	Jer	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequ	on'5	Disca	se				
	uted Id ransit	Examiner	Cause (Disease or injury that initiated events C.								
	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
	cate b physic s the b	edical	d.								
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate that 24 hours after death, within E24 hours after death.  Of the Funeata Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	. If yes, outcome of pregna 1  Live Birth 2 Feta 4 Pregnant at time of a 9 Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	у		2	3d. Date of delive Month	ory Day Year
P.0	that the	by Pł	Part II. Other significant conditions contr	buting to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco us	e contribute to th	e cause of death?
rds,	aquires sen siç nould k							1 🗆	Yes 2	<b>(</b> No 3 □ Prob	pably 4 🗌 Unknown
900	has by	Completed						24a. Was auto			osy findings available npletion of cause of
Ä	sician: The law is certificate has t director, page 2 s		25. Was case referred to medical			26 Pla	ice of Death (Che	1 Tyes	2 🗹 No	1 Yes	2 🗆 No
Vita	Physicia this cert ral direct	To Be	examiner? 1 ☐ Yes 2 🔀 No	pital: 1 <b>X</b> Inpatient 2 🗆	ER/Outpatien	Othe	r		dence 6	Other (Specify)	
of	ing Ph ing Ph ifter th uneral		27. Manner of Death  1   Manner of Death  Natural  5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at	28d. Describe			
sion	ottendi death ctor: A y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm stre		Yes 2 No	28f Location (	Street and	Number or Rural	Pouta Number
Division of Vital Records, P.O.	alor A s after al Direction b		4 ∐ Homicide determined	building, etc. (Specify		et, lactory, office		City or Tov		Number of Autar	noate Nambel,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Examiner	an: To the best of my know On the basis of examination ractitioner: To the best of r	n and/or invest	gation, in my opinior	n, death occurred	at the time, date a	and place, a	and due to the cau	ise(s) and manner stated.
	To the within 2 Comple		29b. Signature and title of certifier  Defarter But	les MD		29c. License	number	0	29d. Date	signed (Month, E	2012
				pleted cause of death (Item	1 23a) (Type, P	rint) Orle	ans St	reo + B	altim	ore, Md	2/287
3	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture					.,	
DUI	Registra		JUN 0 7 2012	Kur B	gar	CA.					

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Month Day Robert S. Martin 11:55а м May 17 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6889 Buttonwood Court Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Month, Day, Year) Aug. 4, 1936 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months 220-34-3414 Washington D.C. **Director** 75 Usual Residence of Decedent 28a-f shov 10b. County with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Frederick 1 Yes 2 X No Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6889 Buttonwood Court 21703 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the 12 Orthopedics Brace Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Julius H. Martin Marion J. Wisner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Grant Place, Frederick, Maryland 21702 Tom Martin/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date ☐ Burial 2 🛣 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.5/18/2012 Frederick, Maryland. 21. Signature of peral Service taufier Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, teaming to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of, Exami nding physician and use as the burial-transi Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗆 Yes 2 🛂 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr performed 2 🗌 No To the Hospital or Attending Physician: Be 25. Was case referred to predical 26. Place of Death (Check only one) Hospital Other: 2 No No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Convey, MD 45 Thomas Johnson Drive, Frederick, Maryland 31. Date filed (Mon 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 23, Physician/ Laura Geraldine MAGAHA 2012 10:32 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown 404 Village Place 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Year 1931 Months 1 M 2 X F Days Hours Month, Day Y 80 Maryland 220-26-7373 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director Hagerstown 1 Yes 2X No Maryland Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral 21742 USA 404 Village Place death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Was Decedon. Armed Forces? 1 ☐ Yes 2 🌠 No Examiner Black, White, etc. ō δ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: white Specify "natural" 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) aircraft mfg. 12 operation technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Etta Bogner Summers Roy Ralph Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 408 Village Place, Hagerstown, Maryland 21742 Rebecca Snyder - friend item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State 5 Department of Important: If it any injury or o cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State Hagerstown, Maryland Rest Haven Cemetery 5/26/12 4 Donation 5 Other (Specify) Signature of Juneral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME Enlist E. Wilson Blvd., Hagerstown, Md. 415 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Years disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to jor as a consequence of: cause. Enter Underlying Physician/Medical Exam Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 this certificate 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 횬 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of s after death. 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation the ' Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours Funeral Medical 29a. Certifier l 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 8068995 2012 25

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Young Tang, and 1130 opal of, Hogerstown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2 0 1 2 9:45 pm Marta Martner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Collingswood Nursing Home 9. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, 02 Days 1 🗆 M 2 🕱 F Chile 87 Director 014-30-4098 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland them 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🕅 No Maruland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11608 Silent Valley Lane 20878 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes, Give Specify: Caucasian Chilean 3 X Widowed 4 □ Divorced Completed Year or Dates. 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pediatrics Physician 5+ permit. Page 1 and 2 should be filed wit Department of Heatth and Mental Hygies Important; If item 27 is marked other t any injury or other traumatic avent \*\*. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ Teresa Soto Alexander Manhood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11608 Silent Valley Lane, N. Potomac, Maryland 20878 Patricia Marta Martner-Hewes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 05/22/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MOIODY 22. Name and Address of Facility Simple Tribute Funeral & Cremation Ctr. 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the dis shock, or heart faile ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence or) ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury B Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial trap Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death g 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform death? 1 ☐ Yes 2 No Yes 2 No certificate within 24 hours after death.

To the Funeral Director, After this certific.
completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Iniury at work? iniurv Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar AMEND#3perMD,5/22/12/EMW,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 312 te 10 eat PM Physician/ Month Margaret E. Martin May 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 6, Day, Year 1912 Days Months Hours 224-60-1925 New York Director 100 1 □ M 2 🛛 F Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Mitchellville Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? oortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 10450 Lottsford Road #4009 20721 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc ģ 1 X Never Married 2 Married Yes 2 X No Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Budget Bureau Statistician 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 2 Frances Evans Harry Wheeler Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 269 Lake Street, Haddonfield, NJ 08033 1 and 2 s of Health item 27 Gary Wheeler Stone/Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of May 17 20c. Location - City or Town, State Page 1 nent of I ant: If it Geo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 X Donation 5 ☐ Other (Specify) Washington, D.C. Center 2012 Washington, D.C.
22. Name and Address of Facilit Columbia Mortuary Services, P.A. Signature Funeral ervice ens /M00969 XIII E 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Pnysician disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown fo Month Day Year Ö signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ď Completed by Acute Chronic Congestive Heart Failure Martin, Margare Division of Vital Récords, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Pulmonary Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 은 1 XInpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dis 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at injury 1 X Natural 5 Pending Investigation 1 Tes 2 No Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Practitionar T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

opm

2

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Francis Freisinger, M.D.

31. Date filed (Month, Day, Year)

MAY 22 2012

D0070427

8600 Old Georgetown Road

Bethesda, MD 20814

May 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/16/2012 11:56 P M Medical JEAN TAVALLETTE MURRELI Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Gaithersburg 8006 Cloverwood Court Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** NJ country) 1 🗆 M 2 🔀 F Months Days Hours Min 67571937 144-30-3191 74 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 屎 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8006 Cloverwood Court 20879 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify "natural", Specify Completed 3 X Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bell Labortories Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Postles, Jr. Julia Harris or other traumatic should and Me 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Jennifer Nellie Washington 8006 Cloverwood Court, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 5/21/2012 Hanover, MD. 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicianz Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and buria The law requires that the death certificate be executed Cause (Disease of I that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Cther (specify) Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; pompleted filled in by the funeral director; p. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 😾 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Fractioner: To the best of my knowledge, deeth occurred at the time idea and clare, and due to the cause(s) and menner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64983 5/18/2012

Registrar

State

Kashif Firozvi, MD, PA, 2101 Medical Park Drive, #200, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	=	For State Registrar	State of Maryland /	-	irtment of F <i>tificate of E</i>		Mental Hy	gien/ Reg. N	001	2	181	23
Physicia	۱/	1. Decedent's Name (First, Middle, Last)	<b>NA.</b>				2. Date of D	eath	Day Yes	ar	3. Time of Dea	
Medic Examine	al .	THELMA  4a. Facility Name (if not institution, give st	MURPH reet and number)	4	4b. City, Town, or	Location of De	05	3	0 50	15	5:15 /	<del>1</del> M
Examine	∍r	Laurel Regional			Laure1	Location of De	atri	4	c. County of D		orge's	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bin	thday)	If Under 1 Year Months Days	If Under 24 H Hours Mi			9.		ace (State or Fo	reign
Director		Usual Residence of Decedent	lM 2 <b>X</b> F 88	Yrs.			June 8	, 19	923 Wa	shi	ngton,	DC
yland -f sho ed at	cto	10a. State 10b. County	10c. City, Tow							100	d. Inside City L	
he Mar or 28a notifi	Pire	Maryland   Charles  10e. Street and Number	Charl	otte	Hall			100.0	Citizen of What	Countr	1  Yes 2	X No
with tl	Funeral Director	13760 Charles Stree	et		20622	2		_	U.S.A.	COUNT	y :	
r item			Was Decedent Ever in U.S.     Armed Forces?	13. V	/as Decedent of Hi Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No erto Rican, etc.)	-	14. Race - A Black, W			
U36 s after ral", o Exam	od pa	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 🎇 No	Specify:				Vhit		
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a completed)		ent's Usual Occupa		rorkina	16b.	Kind of Busine	ess/Indu	ıstry	
rthin 7 rthan the Me	S	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO	NOT use retired)				Own H	OMP		
filed w all Hyg dothe event,		17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maide		Ome		
Aarylal should be and Ment is marker raumatic e	ှ	Walter Emmett					a Chris					_
Man she nan nan rau	1	19a. Informant's Name/Relationship (Type Patsy Thomas			g Address (Street a							22
Saltimore, IN bermit. Page 1 and 2 Department of Health mportant: If item 27 any injury or other tr	1	20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ R	20b. Place o	f Dispos	sition (Name of atory or other plac		Date		Location - City			
timent trant: Tage tant: I		4 ☐ Donation 5 ☐ Other (Specify)	Metrop	oli	tan Crema	itory 5	5/31/2012		<b>le</b> xandr			
baltimore, r permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 4		21. Signature of Funeral Service Licensee	yst M00641	22.	Name and Addres	s of Facility R	aymond	Fun	l. Se	rvi	ce,P.A	٠.
		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death. Do r	not ente	535 Wash	g, such as cardi	n Ave ac or respiratory a	<u>Lа</u> rrest,	Plata	1	Approximate	
Physician/		Immediate Cause (Final disease or condition	RESPIR	24	TORY F	ZAILU	RE				nterval Betwee Onset and Deat	
Medical Examiner		resulting in death)	Due to (or as a consequence	of):				<del>-</del>				
	Je.	Sequentially list conditions, it any, leading to inneed ate	Due to (or as a consequence		s accession		<u> </u>	<u> </u>		+		
cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
be exe	Sal E	resulting in death) Last	Due to (or as a consequence	of):								
	Medical	d d						- 1				
th certification transfer as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy		Ectopic pregnanc	у			23d. Date of		·	
he death of the atter ched for u	) Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗆	Other (specify)				Month	D	ay Year	
s that the	by P	Part II. Other significant conditions conf	tributing to death but not resulting	in the ur	iderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	e to the	cause of death	1?
DIVISION OF VITAL RECORDS, tal or Attending Physician: The law requires is after death.  In Director: After this certificate has been signed in by the f. neral director, page 2 should be din by the f. neral director, page 2 should be a second or the fire of the firest			<u> </u>				_ 1 🗆	Yes :	2 □ No 3 □	Proba	bly 4 Unk	nown
e law r e has b ge 2 s	Completed							an psy ormed?		to com	y findings avail pletion of cause	
an: Th an: Th tifficate tor, pa		25. Was case referred to medical			26. Pla	ace of Death (Cf	1 🗆 Yes	2 💢 1	No. 1 🗆	Yes 2	□ No	
hysici hysici this cer al direc	요	TE fes 2 ANO	ospital: 1 Inpatient 2 - ER/Ou		3 DOA Othe	er: 4  Nursing	Home 5 ☐ Res	idence	6 Other (S)	oecify)		
ding P	:ate:	27. Manner of Death  1 Natural 5 Pending		Fime of njury	28c. Injury work' M 1	rat ? Yes 2 □ No	28d. Describe	how inju	ury occurred			
Atten Atten ar deat ector: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa	rm, stre		ies 2 🗆 No			nd Number or	Rural R	oute Number,	
DIN saffer ral Dir.			building, etc. (Specify)				City or To					
Hos of 24 hot of Functions	Medical	(Check 2   Medical Examine	ian: To the best of my knowledge, r: On the basis of examination and/o	or investi	gation, in my opinio	n death occurre	d at the time date	and place	e and due to t	he causi	e(s) and manner	r stated
To the vithin To the comp		29b. Signature and title of certifier	0	www.uger,	29c. License		r place, and due to	29d. D	ate signed (Mo	onth, Da		
		) h	Simo		1 -	264		٢	5/30	12	~015	
		30. Name and address of person who con				Sutt	F 27 N I	An 1	251 . N	10	2070	7
State	-	31. Date filed (Month. Day, Year)	32 Registror's Signature			~11	- L	~ 1~	·~~ '1	ليو.ت		•
Registra		JUN U 7	2012 Deves	9	parker	-						
DHMH 17 Rev 06-20	111											

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene  1- State Requistrar  Certificate of Death  Req. No. 2 0 1 2 1 8 1 2 4													
			Registrar  1. Decedent's Name (First, Middle, Las	.+1		Cer	tificat	e of L	eath			Reg. No	.2U I	2	18	164
П	Physicia	ın/	Homer Lee Manr								2. Date of De Month	ath 27	y 20°	ar	3. Time o	
ı	Medic Examin		4a. Facility Name (if not institution, give				4b City	Town or	Location of	of Death	May		. County of I		9:35	A M
400	, LXGIIIII	iC.	14429 White Oak F	Ridge				ncoc		or Dougr			shing			
	Funeral		5. Social Security Number 6. Se		e (In yrs. last	t birthday)		r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th		Birthp	lace (State	or Foreign
	Director			<b>∑</b> M 2□F	74	4 Yrs.	IVIORILIS	Days	nours	IVIIII.	(Month, Da			MD	ry)	
	nd how at	<u>ا</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation				00/20/				Od. Inside C	City Limits
	laryla 3a-f s ified	Director	MD Washing	ton	Han	ncock								1		s 2XXNo
	or 28		10e. Street and Number				10f. Zip	Code			- 1	10g. Ci	tizen of Wha	t Coun	try?	
	s 23a	Funeral	14429 White Oak F	Ridge			2	21750	ı				USA			
	death item ner n	Fur	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Deced Yes, spe	dent of His	spanic Orig	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	- <	14. Race - A			
36	after al", or xami	d by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give	No	1	☐ Yes	2 🛛 No	Specify:		•		Specify:			
9	hours natura ical E	Completed	15. Decedent's Ed	Year or Dates.		16a. Deced	ent's Usu	al Occupa	ition			16b k	(ind of Busin	Wh i		
215	n 72 e. nan "r Med	duo	(Specify only highest gra	de completed) College (1-4 or 5		(Give k	ind of wo NOT use	rk done di	uring most	of worki	ng	100.1	and of Busin	533/1110	iu su y	
7	withi ygiene ner th		11		''		Carp	ente	r			Co	nstru	etic	n	
gug	e filed ntal Hy ed otl even	To Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Surname)			
ž	d Mer d Mer mark maric	-	William Manning  19a. Informant's Name/Relationship (Ty	0::-1				_			ylor			_		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ances.	Ţ,	Ruby C. Manning/W		1		_				l Route Numbe lancock				ode)	
ē,	1 and f Hea item other		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Nar	ne of	- 1		ate		ocation - Cit		wn, State	
E O	Page nent o int: If		1 ☐ Burial 2 💢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		netery, crem h s bu r o		•		6/02	/2012	Smit	hshure	. 1	ر ال	
alti	permit. Departn Imports any inju		21. Sign ture of Juneral Service Lice		West											
<u> </u>	8 8 5 6	Ų.	Miller		P.A.Har				0-036	8						
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	r respiratory ar	rest,			Approxima Interval Bet	tween								
- 600	Physician/	1 7	Immediate Cause (Final disease or condition	a Parkin	son's	Disea	ase							1	Onset and 1 Year	Death CS
	Medical Examiner		resulting in death)	Due to (or as a	consequer	nce of):										
4		jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequen	nce of):								+		
	rted d ansit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease on injury)													
	execu an and rial-tra	Ex	that initiated events resulting in death) Last	Due to (or as a	consequen	nce of):								$\top$		
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		d										$\perp$		
387	rtifica ing pl e as t	/Me	IF FEMALE:									Т				
Box 687	ath ce attend for us	ian,	in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal d	death 3 🗌			1				23d. Date of Month		•	Year
ă.	the a	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time or gea	atn 5 🗆	Other (sp	еспу)					Month		Juy	roai
P.O.	that the		Part II. Other significant conditions co	ntributing to death be	ut not resulti	ing in the ur	nderlying (	ause give	en in Part I		23e. Did to	obacco u	use contribut	e to the	e cause of c	leath?
S,	n sign	q pa	Diabetes mellitus	3							1 🗆	Yes 2	X No 3 □	Prob	ably 4 🗌	Unknown
Ö	w req s bee 2 sho	plet	Hypertension								24a. Was				sy findings	
Rec	sician; The law r certificate has b lirector, page 2 s	Completed by	Coronary artery o	lisease							autor perfo	rmed?	deat	h?	npletion of a	sause or
<u>a</u>	cian; ertifica ector,	Be (	25. Was case referred to medical						ce of Deat	h (Check		2 420 74				
Š	Physic this co	မ	1 Yes 2 X No	Hospital:		-			4 ∟ Nu		ne 5 $X$ Resid			oecify)		
n O	ding F h. After funer	ate	1 X Natural 5 ☐ Pending	28a. Date of injur (Month, Day)		8b. Time of injury	M 2	Bc. Injury work?	at res 2 🗆	- 1	8d. Describe h	ow injur	y occurred			
Sio	Atten r deat ctor: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	rv - At home	e, farm, stre			res Z 🖂		28f. Location (S	treet an	d Number or	Rural I	Route Numb	her
Division of Vital Records,	al or / s after ! Dire		4 ☐ Homicide determined	building, etc		.,,	,				City or Tou			riararr	logio ivarrix	501,
_	ospita hour unera	Medical	29a. Certifier 1 X Certifying Phys (Check 2 Medical Examin	ician: To the best of r	my knowled	ge, death or	ccurred at	the time,	date and	place, an	d due to the ca	use(s) a	nd manner a	s state	d.	
	the H hin 24 the F mplete	Me	only one) 3 Certifying Nurs	e Practitioner: To the	best of my	knowledge,	death occi	urred at th	e time, date	e and plac	ce, and due to t	nd place he cause	(s) and mann	ne caus er as st	ated.	inner stated.
	vit 70		29b. Signature and title of certifier	2 min			290	License					te signed (Mo		-	
			Www./DXDA	SUMM)		2 ) == -		D082	58			Ма	ıy 29.	20.	12	
, .			30. Name and address of person who calva S. Baker, MD	ompleted cause of de 747 Nort			,	opre	town	MD	21742					
	Stat	е	31. Date filed (Month, Day, Year)	32. Registr	's Signature	e			LOWIT	, LIL	176					-
	Registra	ır	JUN 0 ·	7 2012 > 12	ana .	A	has	Kel								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Raymond Maxwell Moore May 26. 11:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-Frostburg Nursing & Rehab Center Frostburg Allegany 8. Date of Birth
Sept. 10,1940 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Hours Cross, Director 234-62-3783 71 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Tes 2 No WV Mineral Keyser 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1, Box 256 Rt. items 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1  $\square$  Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 1959-64 White Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Metal Can Setup Department Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic 2 John William Moore Augusta Bertha Cosner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna K. Moore/ Wife 1, Box 256 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) Entombment 6/01/1 Restlawn Memorial Gardens LaVale, MD 22. Name and Address of Facility Signature of Fuperal Service Licenses Smith Funeral Home Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onserand Death Immediate Cause (Final Physician disease or condition resulting in death) Vay C Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coron Completed 1 Yes 2 No 3 Probably 4 Inknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 2 No within 24 hours affer death.

To the Funeral Di ector. After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2/ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 2 Accid 5 Pending work?
1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

Jesus Tan,

31. Date filed (Month, Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

4 Broadway

Frostburg, MD

02124

21532

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 30, 2012 Year Mildred Martin 1630 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Golden Living Center Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth 1 M 2 XF Hours #eb 44.4 917 214-05-7936 95 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. Count iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 302 Massachusetts Ave 21502 USA 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Mamied 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗖 No Specify "natural" Completed 3 → Widowed 4 □ Divorced Specify. white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Alleg. Co. Board of Ed cafeteria cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Harry C. Clarke Laura I. Neat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Cumberland MD 21502 Timothy Martin son 1 and 2 s of Health item 27 20a. Method of Disposition
1 Disposition 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o once. Page 1 St. Mary's Cemetery 6/2/2012 Cumberland MD 4 ☐ Donation 5 ☐ Other(Specify) 21. Signature Funeral Service 22. Name and Carpellif Full eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Approximate shock, or heart failure. List only one cause on Interval Between
Onset and Death Immediate Cause (Final loute Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? Month Dav 2 NO ed by the a Yes Division of Vital Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? <u>م</u> Vascular dementia Ul Leurs & 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed dismiled 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 I within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

only one

29b. Signature and title of certifier

Huna Straliy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.D

625

DHMH 17 Rev 7/2009

To the

D46346

Kent Ave. Stc. 204 Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

6/1/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ K, O'Neill Year Month 05 1230 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Baltimore, M Examiner 4c. County of Death UMMC MD **Baltimore** 5. Social Security Number 107–46–3700 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours Director 57 1 XM 2 | F 12-16-54 Bronxville, NY 10c. City, Town or Location 10d. Inside City Limits Director 28a-f DE New Castle Wilmington 1 Yes 2 XNo 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? be ms 23a must be Funeral 1217 Larkal Drive 19803 USA items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian "natural", or iter Armed Forces Black White etc. by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: white If Yes Give 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Greater Washington Elementary/Secondary (0-12) Director of Membership Board of Trade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ John K. O'Neill, Sr. Ann Nolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 1217 Larkal Drive Wilm., DÉ Health a Colleen G. O'Neill (wife) 19803 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Reg 4 Donation 5 DOMer (Specify) Joseph on the St. May 24, 2012 Wilmington, DE 22. Name an ress of acility Signature of Fun McCrery & Harra Funeral Homes & Crematory, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ Melanoma disease or condition resulting in death) ucar Medical Due to (or as a consequence of): Examiner month s Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and the for use as the burial-transit Brain metastase that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 L Yes 2 L 9 D Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy perform 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 **X**No 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

12

29b. Signature and title of certifie

31. Date filed (Month, Pay, Year)

MAY 22

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

/annorsdell

32. Registrar's Signature

P25670

29d. Date signed (Month, Day, Year)

St Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 15, 2012 12:21 P M Carole June Onley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills Prince George's 6809 Robinia Rd. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 234-52-4313 1 🗆 M 2 🗓 F 79 Director June 11, 1932 West Virginia Yrs. shov 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State death with the Maryland Director or 28a-f s notified Temple Hills Md. Prince georges 1 K Yes 2 □ No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe 9 must be Funeral 23a 20748 USA 6809 Robinia Rd. iral", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify Specify: White "natural". 3 Widowed 4 Divorced ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Buyer (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Retail and Mental Hygier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, f Health and Mental F item 27 is marked of other traumatic evel မ Gladys Hutchinson Arthur Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6809 Robinia Rd. Temple Hills, Md. 20748 John Henry Onley/Spouse item 2 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or ot ō Cedar Hill May 21, 2012 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, INC 21. Signature of Funeral Service Licensee 101555 6633 Old Alexandria Ferry Rd. Clinton, Md. 20735 Approximate Interval Between Onset and Death 23a. Parvi. Enter the disease, or complications that become thock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physiciany therosc Medical to (or as a consequence of) **Examiner** Sequentially list conditions Due to lor as a conse uence of cause. Enter Underlying Exam Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Pregnant at time of death 5 Other (specify) ☐ Pregnant been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the director, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred injury 5 Pending s after death.

I Director: Af
ed in by the fu Investigation Accident 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after
To the Funeral Directormpletely filled in br City or Town, State) Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title

00.3

State Registrar 31. Date filed (Manth J

5625 Allentown Road, Suite 101, Camp Springs, MD 20748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fatima Hussein

AMEND Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar MEND#25perDME;5/22/12;BMW,McCo Reg. No. 2 Certificate of Death 3. Time of Peath 2. Date of Death Month Physician/ 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. Countly of Death De Q C Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthdav 6. Sex/ 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 261-92-8864 84 **Director** 1 □ M 2 🖾 F Nov. 25, 1927 Korea Usual Residence of Decede 28a-f show with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2X No MD Montgomery Gaithersburg 10e. Street and Number ō 10g. Citizen of What Country? Funeral 23a 9 Chestnut Street, Apt. 205 20877 USA items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) -14. Race - American Indian, "natural", or iten edical Examiner Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Asian If Yes, Give Year or Dates 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify er than "natur , the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Pharmacv is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hiizu Takei Sumiko Suzuki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Grover L. O'Connor/Husband Chestnut Street, #205, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 22 May 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2012 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such w cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (c dm Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery May 18, 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown g Unknown Part II. **Other significant conditions** contri**∦**uting to death but not resulting√in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been Piconnor, Sachiko 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an lensi After this certificate has autopsy performed 1 Yes 2 No filled in by the funeral director, 25. Was case referred to edical 26. Place of Death (Check only one) examiner? Other: Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1. Notural 2. Accident 5 Pending injury Investigation Unk 1 Yes 2 Divo on 28f. Location (Street in gumbing CTNUT)
City or Town 11118 6 Could not be 3 Suicide Place of Injury - At home, farm street, factory, office building, etc. (Specify) 4 Homicide determined GATTHERSBURG Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 2 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NAY 22 2012 Registrar's Signature State Registrar

5480

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** PAEK CECILIA 0651 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F 74 174-50-7819 Director May 15,1938 Korea Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at Fairfax 1 ☐ Yes 21 No Director VA Reston 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 11557 N. 20190 Shore Dr. #12 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature." 1 Yes 2 had Yes 2 had Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: \$ Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Du H. Kim Kye S. Ko 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11557 N. Shore Dr., #12, Reston, VA 20190 Andrew Paek/Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition remetery, crematory or other place)
Fairfax Memorial
Park 19, 1 X Burial 2 Cremation 3 Removal from State May Fairfax, VA 4 Donation 5 Other (Specify) 2012 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 21. Signature of Funeral Service Licenses CC0423 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MULTI - SYSTEM OFGAN FAILURE
Due to (or as a consequence of): disease or condition resulting in death) SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) EPIDERMAL TOXIC resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? ☐ Live birth 2 ☐ Fetal death 3 - Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 1 Yes 2 No 25. Was case referred to medical Be 27. M completely filled in by the funeral

Examiner attending physician and d for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the signed by has

death with the Maryland

Certification: To

ao caoo roioirea to mealeas			20. I lace of Dea	tit (Oneck only one)
aminer? Yes 2 □ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 D	OOA Other: 4 I Nursing He	ome 5 ☐ Residence 6 ☐ Other (Specify)
anner of Death ☐ Natural 5 ☐ Pending Accident investigation	11/ 130 2012	Injury	28c. Injury at Work? 1 ∐ Yes 2 X No	28d. Describe how injury accurred TO XL EPIDER MAL NECLOCYSIS DUE TO DOXYCYCINE USE
☐ Suicide 6 ☐ Could not b☐ Homicide determined			ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1155-7 N SHORE OR \$12, RESTON V
artifice 1 Cortifuing Dh	voicion. To the heat of my know	uladas daeth securra	d at the time date and class	and due to the source(a) and manner as stated

RES - 000

(check only one)	2 Medic
29b. Signature and	title of certif

3

and manner stated. 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

4940 Eastern Avenue, Baltimore, MD, 21224

2012

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 21 2012

KLAFF JUSTIN 39. Registrar's Signature

**ORIGINAL** 

within 24 hours a

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	Type or Pri						_		_	le.	
	•	For State Registrar		State of M	aryland	•	artment of I tificate of I			nentai ny	Reg. N	001	2	18131
Physicia	n/	Decedent's Name		<sup>st)</sup> hnson Page	2					2. Date of De Month May	16	ay 20Î	ey	3. Time of Death 11:00 p M
Medic Examin		4a. Facility Name (if		street and number)			4b. City, Town, o	r Locatio	on of Death	lidy		c. County of D		11.00 р
LXCIIIII	٠.	47 Gi	lley Road	l			Pe	rryv	7ille			Cec	il	
Funeral Director		5. Social Security N 215-32-4	4267	Sex 7. Ag	e (In yrs. las 76	t birthday) Yrs.	If Under 1 Year Months Days	If Unc	der 24 Hrs. s Min.	8. Date of Bir OCT • 1	th Year	1935 g.		ryland
nd how at	'n	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	cation						10	d. Inside City Limits
Maryla 8a-f s tified	Director	Maryland	Ced	:i1			Pe	rryv	7ille					1 ☐ Yes 2 🛱 No
with the N 23a or 2 ist be no		10e. Street and Nur 47 Gil	nber ley Road				10f. Zip Code	.903			10g. (	Citizen of What	S $\cdot$ A $\cdot$	
ter death or items miner m	by Funeral	11. Marital Status	ied 2 🔀 Married	12. Was Decedent Armed Forces?	No	ľ	Vas Decedent of H	an, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - A Black, V		
ours aff	eted	3 Widowed	4 Divorced	If Yes, Give Year or Dates.1	954-5	/	Yes 2 X No		aty: 		401	Specify:		ite
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spe Elementary/Sec Twe1ve	onday (0-12)		5+)	(Give I life, D	dent's Usual Occup kind of work done O NOT use retired) Block Ope	during m		ing	Co	Kind of Businentail Imingt		Delaware
oe filed w ental Hygi ked other c event, t	To Be	17. Father's Name (		Page	1_			1	other's Nam	e (First, Middle	, Maide	n Surname)		
2 should I th and Me 27 is marl traumati		19a. Informant's Na					ng Address (Street						, Zip Co 219	
1 and of Heal item 2		20a. Method of Disp	position			ce of Dispo	sition (Name of natory or other pla		<del></del>	Date	_	Location - Cit	y or Tow	n, State
Page tment tant: It jury or			5 Cremation 3 L	Removal from State		lncipi	Lo Cemete	ry	<u>i                                      </u>	23/12				Maryland
permit Depart Impor any in		21. Signature of Fu	neral Service Licer	Pattersi	n. 6	22 I E	Name and Addre Lee A. Pa Perryvill	ss of Fa tter e, N	cility rson & Mary1a	Son Fund 2190	iner 03-0	al Hom 766	e, I	P.A.
Physician/ Medical		23a. Part 1. Enter t shock, or hea Immediate Cause ( disease or condition resulting in death)	rt failure. List only Final	nplications that cause one cause orreach lin a.	e. arco	ns C	er the mode of dyir	ng, such	as cardiac o	or respiratory a	rrest,			Approximate nterval Between Onset and Death
Examiner				Du ⊮o (or as	a conseque	nce of):		0	,					
ecuted and I-transit	Examiner	Sequentially list confidence in any, leading to in cause. Enter Unde Cause (Disease or	rlying linjury	Due to (or as	d conseque	into the								
be executed sician and burial-transi		that initiated event resulting in death)		Due to (or as	a conseque	nce of):			·					
fficate ig phys as the	Medi	IF FEMALE:		- u										
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	23b. Was decedent in the past 12 1  Yes 2  Unknown	months? ☐ No	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 - Fetal	death 3	Ectopic pregnan Other (specify)	су				23d. Date o Month		y ⊘ay Year
uires that th signed by Id be detac	d by Ph	Part II. Other signit	ficant conditions	contributing to death t	out not resul	ting in the u	inderlying cause gi	ven in P	art I.					cause of death?
ne law requ e has beer age 2 shou	Completed by					_				24a. Was auto perf	psy ormed?	prior deat	to com	sy findings available pletion of cause of
an: Th	Be C	25. Was case referr examiner?	ed to medical				26. F	lace of E	Death (Chec	1 ☐ Yes k only one)	2 🕰	NO I	res 2	E3 NO
hysici his ce I direc	To E	1 🗆 Yes 2					nt 3 🗆 DOA Oth	ner: 4 🗆	Nursing Ho	ome 5 🖺 Res	idence	6 Other (S	pecify)	
ending Plath. or: After the funera	Certificate:	27. Manner of Deat  1 Natural 2 Accident	h 5 Pending Investigatio 6 Could not			8b. Time of injury	wor		_	28d. Describe	how inj	ury occurred		
tal or Att rs after d al Direct ed in by t		3 ☐ Suicide 4 ☐ Homicide	determined			ne, farm, str	eet, factory, office			28f. Location ( City or To			r Rural F	Soute Number,
ne Hospi in 24 hou ne Funer	Medical	(Check 2 only one) 3	P ☐ Medical Exam	ysician: To the best of niner. On the basis of e rse Practioner: To the	examination a	and/or inves	tigation, in my opini	ion, deatl	h occurred a	t the time, date	and pla	ce, and due to	the caus	e(s) and manner stated
To the within comp		29b, Signature and	title of certifier	m	/		29c. Licens					ate signed (M		ay, Year)
		20 Name and addr	ace of person who	completed cause of	leath (Item 9	3a) /Tuna   E	Print\							

6+IVA

State Registrar 31. Date filed (Month, Day, Year)

NAY 2 2 2012 GAL VEZ MD 32. Registrar's Signature

6258. UNION AVE HAVRE DE GRACE MO. 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 6:30 P Debra L. Pentz May 2012 Medical 17 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6208 Douglas Circle Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Hours Min (Month, Day, Year) 220 66 8537 57 Director 1 □ M 2XX F Yrs March 31, 1955 Washington DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 🗌 Yes 2 😾 No Charles Waldorf Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a c \t be r ö Funeral must 6208 Douglas Circle 20601 United States items Page 1 and 2 should be filed within 72 hours after death \text{nent of Health and Mental Hygiene.} 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Examiner Ь ģ 1 Never Married 2XX Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Prince Georges Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Donald Mastracco Betty Biggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6208 Douglas Circle, Waldorf, MD 20601 Russell Pentz ,II (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory May 18, 2012 Clinton, MD 22. Name and Address of Facility Lee Funeral Hone, Inc 6633 Old Alexandria 21. Sign / re of Funeral Service Licen MO1555 Ferry Road, Clinton, MD20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each lim. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) years Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months' 1 Yes 2 No Month Day Year Pregnant at time of death signed by the at be detached f Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one title of certifier 29b. Signature an 29c. License number 29d. Date signed (Monthi Day, Year,

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12<sup>Day</sup> Physician/ 2012 May 12:20 AM Hilma Elizabeth Petersen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Elkton Care and Rehab E1kton 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**XX**F Jan. 23, Months Hours Year 1921 Nebraska 91 217-20-4311 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2xxXNo Maryland Cecil North East 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21901 United States 433 Lums Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Company Secretary of Human Resources Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ Grace Eva Hale Arnold Bradford Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana J. Petersen / Son Independence Way, Newark, Delaware 19713 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mayerdale Crematory 20a, Method of Disposition Date 20c. Location - City or Town, State May 14, 1 Burial 2 X Cremation 3 Removal from State Newark, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility Crouch Funeral Home, P.A. Signature of Runeral Service Licenses 127 South Main Street, North East, Maryland21901 Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. 23a. Part 1. Enter the disease Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Year 5 Other (specify) Day Pregnant at time of death P.0. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 4 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident 2 No Investigation nours after death neral Director: / Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 3 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar MI)123 SINGERLY H

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Phyllis Sandra Poole May 2012 8:40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Davs Hours Min. Director 263-58-3445 1 🗆 M 2 🔀 F 73 05/20/1939 New York Usual Residence of Decedent r 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland St. Mary's Avenue 10e. Street and Number ō 10f. Zip Code r items 23a or ner must be r 10g. Citizen of What Country? Funeral 37455 River Springs Road 20609 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. "natural", White 3 Widowed 4X Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) . Hyglene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Real Estate Property Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ဂ Glenn Lobdell Marion Bush and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37390 River Springs Road Avenue, MD Kevin Pace Poole/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place; 4 ☐ Donation 5 ☐ Other (Specify) Charles MemorialGrds 05/30/2012 Leonardtown, MD grature of Funeral Service Lices 22. Name and Address of Facility—Gardiner Funeral Home, Mattingley—Gardiner Funeral Home, 41590 Fenwick Street Leonardtown, MD P.A. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician Breast disease or condition resulting in death) Causes Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 5 Other (specify) 1 Yes 2 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be a Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate Yes 2 No 1 🗌 Yes eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) the Hospital within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 042597 dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Jeffrey C.

Brown, MD

26840 Point Lookout Road Leonardtown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19 May 2012 4:00  $A^{\mathsf{M}}$ Ky1e Timothy Quinn, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick 107 6950 Exetor Court, Apt. Frederick r 1 Year | If Under 24 Hrs Days Hours Min. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1 🔀 M 2 🗆 F Min. (Month, Day, Year) 09 Nevada 3 Jan. **Director** 539-65-7187 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a State with the Maryland must be notified at Director 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country? ö ıral", or items 23a Examiner must be Funeral 6950 Exetor Court, Apt 107 21703 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12 Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after White If Yes, Give Year or Dates 1 Yes 2X No Specify. "natural", 3 Widowed 4 Divorced ed other than "natur event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 0 None None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked မ of Health and Ments item 27 is marked other traumatic e Lee Timothy Quinn Richale Haney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6950 Exetor Court, #107 Frederick, Maryland 21703 Kyle T. Quinn / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Frederick, Maryland Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Fin Service Licensee Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Year Pregnant at time of death Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2₺ No 3☐ Probably 4☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🛣 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) s after death. Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29c. License number 29d. Date signed (Month, Day, Year) D17794 11P 24

State Registrar 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Reimann, William DOB 111201929 TOD 5/17/2018 TOD 1650

			Please Type or Pr							gible.	
			For State of N	/larylanc		artment of F tificate of D	lealth and M				
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	uncate or L	)eati i	2 Date of Dea	th 2	112	3. Time of Death 6
П	Physicia		William F.G. Reimann,	Sr.				Month 5	17 <sup>Day</sup> 20	) 1 <sup>Year</sup>	1650 р м
	Medic Examir		4a. Facility Name (if not institution, give street and number, Atlantic General Hosp			4b. City, Town, or Berlir	Location of Death		4c. Count	y of Death	r
	Funeral			ge (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	) Vear	9. Birthp	lace (State or Foreign
	Director		212-28-1717	2	Yrs.	Months	Tiodis Iviiii.		-1929	MD	, , ,
	show lat	ا ا	10a. State 10b. County	-	Town or Lo	cation				1	0d. Inside City Limits
	Maryla 28a-f otifiec	irect	MD Worcester	Wha	leyvi	ille					1 🗆 Yes 💥 No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	ath wi	nuel	7924 Circle Road  11. Marital Status 12. Was Deceden	t Ever in U.S.	13. \	21872	spanic Origin? (Spe	ecify Yes or No-	USA 14. Rat	ce - Americ	an Indian.
21215-0036	72 hours after death with the Maryland n"natural", or items 23a or 28a-f show ledical Examiner must be notified at	Completed by F	1  Never Married 2  Married 1	?		f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Bla	white,	etc.
5-0	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)		(Give		ation during most of worki	ing	16b. Kind of E		
121	hin ne. tha	Com	Elementary/Secondary (0-12) College (1-4 o	r 5+)		O NOT use retired) aurant l	Manageme	nt	Chicke	_	Tieu
	filed wit al Hygie d other vent, th	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surnam	ne)	
ylar	should be file n and Mental I 7 is marked o raumatic eve	입	John Reimann				Hazel H	lopkins			
Maryland			19a. Informant's Name/Relationship (Type, Print)				Road, W				
d)	and Hea		Deborah Jones/Daughte 20a. Method of Disposition			sition (Name of matory or other Na		Date	20c. Location		
mo	Page 1 nent of int; If i		1 ☐ Burial 2X Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	· · ·		natory or other dad rematio:	1	3-2012	Dover	, DE	
Baltimore,	permit. Page 1 a Department of I Important; If its any injury or of		21. Signature of Funeral Service Licensee	ртгс		Name and Addres	ss of Facility 91	7 W. 3	sabel		
	70 E 8 9		23a. Part 1. Enter the disease, or complications that cause		F	uneral 1	Home Sa	lisbur		2180	
	N		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I Immediate Cause (Final	ne.	. Do not ente	er tile mode of dylif	y, such as cardiac c	or respiratory an	est,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition	s a conseque	ence of):						
-	Examiner	L	Sequentially list conditions, b.								
	sit q	Examiner	if any, leading to immediate Due to (or a cause. Enter Underlying	s a conseque	ence of):						
	executed an and rial-transit	Exar	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or a	s a conseque	ence of):						
0		ical	d						_		
68760	tificate ng phy e as th	Med	IF FEMALE:								
Box 6	ath certificate be e attending physicia for use as the bur	Physician/Medica	in the past 12 months?	n 2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	су			ate of delive Ionth	ery Day <b>Ye</b> ar
Ö.	hat the dea ed by the a detached i	hysic	1 Yes 2 No 4 Pregnan 9 Unknown 9 Unknown		saur o'c						
ls, P.O.	gan St	β	Part II. Other significant conditions contributing to death	but not resu	Iting in the u	underlying cause gi	ven in Part I.				pably 4 Unknown
corc	has been sign 2 should I	Completed						24a. Was	sy	prior to co	osy findings available mpletion of cause of
Re	; The la cate ha r, page							1 Yes	rmed? 2 No	death? 1 Yes	2 No
ita	ysician; The is certificate director, pag	Be C	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	0 D F	D/O	_ Oth	ace of Death (Chec		C \(\sigma\)	has (Casaife	1
of V	g Phy er this neral d	6; 10	27. Mann f Death 28a. Date of i	njury 2	-R/Outpatiei 28b. Time of injury			28d. Describe h			)
on	ttending F death. stor: After y the funer	fical	1 Natural 5 Pending (Month, I	Jay, Tear)	ii ijui y	M 1 🗆	Yes 2 No				
Division of Vital Records,	To the Hospital or Atteno within 24 hours after death To the Funeral Director: / completely filled in by the	al Certificate;	4 Hamicide determined 28e. Place of I	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location (S City or Tow		ber or Rurai	Route Number,
	the Hospi hin 24 hou the Funer mpletely fil	Medical	29a. Certifier (Check only one)  1 / Certifying / ysician: To the best 2   Medical xaminer: On the basis of 3   Certifying Nurse Practitity ner: To	f examination	and/or inves	tigation, in my opini , death occurred at	on, death occurred a the time, date and pl	t the time, date a	nd place, and d	ue to the ca	use(s) and manner stated.
	To t		29b. Signature and title of certifier				53612		29d. Date sign	112	
_			30. Name and address of person who completed cause of Andrea W Barer M	D9	733	Healthi	vay Dr	Berlin	inc	217	7(1
	Sta Registr		31. Date filed (Month, Day, Year) 32/Regit	strar's Signatu	ire	we .	U				
DHV	4H 17 Rev 06-		WAS TO BE	- 1	1		·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 16, 2012 Doris 9:32 В. Rusch Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3318 Estelle Terrace Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Director 238-14-3327 1 □ M 2 🗓 F 92 Yrs. 17, 1920 Jan. NewJersey be filed within remaining thems 23a or 28an arked other then "natural", or items 23a or 28an arked other then "natural", or items 23a or 28an arked other then "natural", or items 23a or 28an arked other then "natural". 10b. Count 10c. City, Town or Location 10d. Inside City Limits Maryland 1 🗌 Yes 2 🖾 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3318 Estelle Terrace 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes Give 1 Yes 2 No Specify 3 A Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked or John Gordon Bentley Maude Quillan of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon B. Rusch/Son 3318 Estelle Terrace, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 of begardment of bimportant: if ite 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State any injury or May 23, Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
More than 40 Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of) yrs. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): nding physiciam and use es the burishman that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No ò Month P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 🖾 No Hospital or Attending Physician: **Division of Vital** funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Anatural 5 Pending injury work?
1 Yes 2 No ours after death.

leral Director: Af
filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D completely filled Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sianatu and title 29d. Date signed (Month, Day, Year) D 32417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Rahul Gilotra, MD

31. Date filed (Month, Day,

12016 Georgia Avenue, Wheaton, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Albert Lee Robinson Physician/ May 20, 2012 5:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Calvert 3425 Leitches Wharf Road Prince Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours August Day 1941 1 X M 2 D F Maryland 220-38-1873 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marian. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Prince Frederick 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20678 3425 Leitches Wharf Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. <u>م</u> 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates. 69 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Della Frances Gatton James Briscoe Robinson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 Leitches Wharf Rd. Prince Frederick Maryland 20678 Linda Lou Robinson—spouse Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 05/23/2012 Alexandria Virginia 4 Donation 5 Other (Specify) Metropolitan Funeral Service 22. Name and Address of Facility Rausch Funeral Home PA Signature of Euneral Service Licenses 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i.i.n disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last attending physician To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes Natural 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a Certifier \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 212 Prince Frede 31. Date filed (Month, Dav. Year) 32 Regist State 22

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2012 May 00:30 AMM Sara E. Robinson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Ceci1 Rising Sun Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min. (Month, Day, Country)
Pennsylvania Director 195-14-2556 Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Chester Downingtown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 350 East Pennsylvania Avenue Apt. 19335 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2XXNo 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify White 3 ▼ Widowed 4 □ Divorced Specify. Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary School District permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumostic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Lauffer Sara Helms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce L. Miller / Daughter 953 Leeds Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MayDay1. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hephzibah Cemetery 2012 Signature of Blacal Service Li 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ neumorgia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 📶 No 1 🗌 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 29a. Certifier Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat re and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

COLONIAI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. O

Lottin

31. Date filed (Mont)

100

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	State of M		d / Depa	artmen	t of H	lealth		-		gible.	1011.0
Physicia	in/	Registrar  1. Decedent's Name (First, Middle, Joseph Scott Ri	,		Cer	tificate	OIL	<i>Jeain</i>		2. Date of Dea	ath Day	Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution,	give street and number)			, ,	Town, or	Location	of Death	May 1		y of Death	3:07 A M
Funeral Director		166-30-3390		ge (In yrs. Ia	ast birthday)  Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da June 2	h y, Year)	9. Birth	place (State or Foreign
aryland a-f show fied at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Freder	rick		, Town or Loc				l				10d. Inside City Limits
ith with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 1322 Appletree			- I Cuoi	10f. Zip		1703			10g. Citizen of United		ntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces  1 XX Yes 2 If Yes, Give Year or Dates.	Ever in U.S 1 942 19	953 13. V	Vas Deced Yes, spec	ify Cubai	n, Mexicar	n, Puerto	cify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White,	etc.
within 72 hou giene. er than "natu , the Medical	<b>Completed</b>	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12	t's Education		16a. Deced	ind of wor NOT use	k done d retired)	uring mos				ntgom	dustry nery County chools
ld be filed Mental Hy <b>arked oth</b> <b>atic event</b>	To Be	17. Father's Name (First, Middle, La Frederick Rindf								immons	Maiden Surnan	re)	
and 2 shou Health and Health and Her traum		19a. Informant's Name/Relationsh Daniel Rindfuss			1322	Apple	etre				, City or Town, , MD 21	703	
it. Page 1 structurent of H rtant: If ite njury or ot		20a. Method of Disposition  1	pecify)	CE	lace of Disposemetery, crem	n Cre	mato	ry		7, 2012		ick,	Maryland
permi Depar Impo any ir		21. Signature of Funder Service Li	<u>//</u>		[95	01 Ca	toct	tin M	lount	ain Hwy		Cody	P.A. MD 21701
Physician/ Medical		23a. Part 1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	ny one cause of each lin	e. EUN	10n)		e or aying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	SIC	Obs	ton	ctiv	e 1	u/n	nonary	dispo	150	
be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequ	ence of):					- /			
ficate be e g physicia as the bur	<b>dedical</b>	7/	d										
To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 Fetal	I death 3 🗔	Ectopic p Other (sp		у			1	ate of delive	ery Day Year
quires that t en signed b ould be det	by	Part II. Other significant condition	ns contributing to death	out not resu	ulting in the u	nderlying o	ause giv	en in Part	1.		obacco use con Yes 2 🗆 No		ne cause of death?
The law rec ate has be page 2 sho	Completed												psy findings available mpletion of cause of
cian: entific ector,	Be	25. Was case referred to medical examiner?	Hospital:				_	ce of Dea	th (Check	only one)			
Physic this or	: To	1 L Yes P L No 27. Manner of Death			ER/Outpatien			N.			ence 6 Oth		)
ttending I death. tor: After / the funer	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could n	(Month, Da	ly, Year)	injury	М			No		ow injury occur		
pital or A burs after eral Direc filled in by		4 Homicide determing	28e. Place of Inbuilding, ef	c. (Specify)				1-4		City or Tow			
o the Hos ithin 24 hr o the Fun ompletely	Medical	(Check 2 L Medical Ex	caminer: On the basis of Nurse Practitioner: To the	examination	and/or investi	igation, in n	ny opinio	n, death oo ne time, da	ccurred at	the time, date a ce, and due to the	nd place, and du	e to the cau	use(s) and manner stated. stated.
, X		100	MD ho completed	Janth At-	220/ 75::-	Ī	>6	04	17		5-11	7-12	
6		30. Name and address of person w Herwey Sh 31. Date filed (Month, Day, Year)	al, 65	_ 7	omers	Joh	nso	n DI	/,	Frede	NICE	MD	21702
Stat		MAY 2	2012	ur o olynati	A. A	acke							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 14, 2,012 0040 Randolph James Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgemory If Under 1 Year Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral Director** 79 578-40-4835 1 X M 2 🗆 F Nov.5,1932 Virginia Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f D.C. Washington, D. C. none 1 Yes 2 No 10e Street and Number 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 20012 6501 14th. Street, N. W.Apt.303 USA items 12. Was Decedent Ever in U.S. Armed Forces? 2 / 23 / 51 1 Yes 2 1 12 / 54 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Government Printing Offide Federal Govt. 12th. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Randolph Earl Brown Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other trau 6501 14th. St. N.W. Apt. 303 Wash. DC20012 Mary Randolph/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/25/'12 Brentwood, MD Lincoln 21. Signature of Funeral Latney's Funeral Home ery ce Licensee 22. Name and Address of Facility cc0278 3831 Georgia Ave., N.W. Wash. DC20011 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia Spiration disease or condition resulting in death) Medical Due to (or s a consequence of): **Examiner** erebrovascular accident Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events tibrillation requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for 1 in the past 12 months? 1 Yes 2 No Month Pregnant at time of death Day Year n signed by the a 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Adenocarcinoma 1 ☐ Yes 2 ☐ No 3 ☐ ,Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an After this certificate has Deep vein thrombosis performed the Hospital or Attending Physician: The 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident 3 Suicide 4 Homicide М 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: Completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of certifie 29c. License number

Registrar

7600

atasha

CARROLL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

AVENUE,

TAICOMA

D53199

PARK

Natasha A. Lamming-Lee, M.D.

MD 20912

5/14/12

			Ple	ase Type or						-		-	le.		
			For				artment of		and N	Mental Hy	ygien	е			
			- State AMEND#20bpe		MW,MbCb	Cei	tificate of	Death			Reg. N	10. 2 0	12	18142	
	Physicia	ın/	1. Decedent's Name (First, Midd Jeanette M.							2. Date of D Month	D	2012 Y	ear	3. Time of Death	
,,,,,	Medic Examin		4a. Facility Name (if not institution		oer)		4b. City, Town,	or Location	of Death	May 1		c. County of	Dooth	6:05 ам	
	Exami	iei	Montgomery Hos		•		Rockv		Of Death		4	Monts Monts		rv	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. k	ast birthday)	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of B		19		lace (State or Foreign	
	Director		230-14-4756 Usual Residence of Decedent	1 □ M 2 🖾 F	93	Yrs.	I Says	Tiodis .	141111.	May 3				m ginia	
	and show	ō	10a. State 10b. Count	y	10c. City	y, Town or Lo	cation			1 0	, -, -			0d. Inside City Limits	
	Maryl 28a-f ptifiec	Director	MD Mo	ontgomery		Takom	a Park							1 ☐ Yes 2¾☐ No	
	a or h		10e. Street and Number		-		10f. Zip Code				10g. C	Citizen of Wha	at Coun	try?	
	ms 2; must	Funeral	108 Sherman A		lant Francis III 6	140.1	209		1 1-0 (0-		L	USA			
ယ	or ite	by Fi	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Ma</li></ul>	12. Was Deced Armed Ford 1 Yes	ces?		Was Decedent of f Yes, specify Cul	Hispanic Or pan, Mexica	ngin? (Spe n, <b>P</b> uerto	ecity Yes or No Rican, etc.)	)-		White, e	etc.	
8	irs eft	edt	3 ₺ Widowed 4 □ Divorce	1 100		1	I ☐ Yes 2 🖾 N	o Specify	<i>'</i> :			Specify: W	hite	2	
5-(	72 hou	Completed		ent's Education nest grade completed)		(Give	dent's Usual Occu kind of work done	during mos	st of work	ing	16b.	Kind of Busi	ness/Inc	lustry	
12	ithin 7	S	Elementary/Secondary (0-12)	College (1-4	1 or 5+)		o NOT use retired <b>ephone</b> C	,	or		Т.	alanho	na (	Company	
ğ	iled w	Be	17. Father's Name (First, Middle,	Last)		101	ephone o	1		e (First, Middle			iie (	Ompany	
-	Menta arred	욘	Ernest Lee Mc	Farland				Mar	y Ed	na Guye	er				
Mar	shour and 7 is m		19a. Informant's Name/Relations Marshall C. Gl.			19b. Mailir	ng Address (Stree	t and Numb	er or Rura	al Route Numb	er, City o	or Town, Stat	e, Zip C	rode)	
e,	and 2 Health		20a. Method of Disposition	35561/5011	20b B	ل	9 Haddoc	K Koa			<del>-</del>	VA ZZ Location - Ci		. 0	
Ω	age 1 ent of nt: if ii y or o		20a. Method of Disposition  1 🖾 Burial 2 $\square$ Cremation 3 $\square$ Removal from State  4 $\square$ Donation 5 $\square$ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cedar Hill Cemetery  20c. Local May 29  Cedar Hill Cemetery  2012  Suit1												
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should to filed within 72 hours efter death with the Maryland Department of Health and Mertlat Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumati event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service			,									
<u> </u>	P S E E		Ileif E.	Signature of Funeral Service Licenside  22 Name and Address of Facility Francis J. Collins Funeral Hom 500 University Blvd. W., Silve											
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that ca only one cause on eac	used the death h line.	n. Do n <b>ot e</b> nte	er the mode of dy	ng, such as	cardiac o	or respiratory a	errest,			Approximate Interval Between	
, mar F	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Conge	stive ]	Heart	Failure							Onset and Death	
	Examiner		resulting in death)		ras a consequ .omyopa									-	
		ner	Sequentially list conditions, if any, leading to immediate	b	r as a consequ								+		
	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с											
	ath certificate be executed attending physician and for use as the burlal-transit	<u>6</u>	resulting in death) Last	Due to (o	r as a consequ	ience of):									
260	physic physic the b	edic		d									+		
89	certific nding use as	W/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna	ncy					Ĭ	23d. Date of	of delive	rv.	
Box 68760	death ne atte ed for	slcia	in the past 12 months?  1  Yes 2 No		irth 2 🗌 Feta ant at time of d		Ectopic pregnar Other (specify)	ıcy				Month		Day Year	
P.O.	requires that the des been signed by the s should be detached	Completed by Physician/Medic	9 Unknown  Part II. Other significant conditi			ulting in the u	ndorhing seuse s	iven in Dest		1					
o. O.	res tha signed d be d	d by	COPD	ons contributing to de	attribut not resi	uning in the d	rideriying cause g	iven in Fan	· I+					e cause of death?	
ord	requi been shoul	lete								24a. Was				sy findings available	
Sec.	he law te has age 2	отр								auto perf	opsy formed?	prio dea	r to con th?	npletion of cause of	
<u>=</u>	nysician: The lavins certificate has	BeC	25. Was case referred to medical examiner?	4			26. 1	Place of Dea	ath (Check		211	Noj 1L	Yes	2 □ No	
<b>Ξ</b> ;	hysic this ce al dire	욘	1 Yes 2 🖾 No											e	
Division of Vital Records,	iding Phy th. After this funeral o	ate	27. Manner of Death  1 A Natural 5 □ Pendi	9	finjury , <i>Day</i> , Year)	28b. Time of injury	wo	k?		28d. Describe	how inju	iry occurred			
sio	Atten r deat sctor: by the	Certificate:	2 Accident Invest 3 Suicide 6 Could 4 Homicide determ		f Injury - At ho	me, farm, stre	M 1 L	Yes 2	I NO	28f. Location	(Street ar	nd Number a	r Rural I	Route Number,	
<u>≤</u>			4 di Homoldo delem	building	g, etc. (Specify)	)			- 1	City or To				,	
	Hospi 24 hou Funer tely fil	Medical	(Check 2 L.) Medical	g Physician: To the be Examiner: On the basis	of examination	i and/or invest	idation, in my opin	ion, death o	ccurred at	the time, date	and place	e and due to	the cau	se(s) and manner stated	
	othe vithin 2 othe omple		only one) 3 Certifying 29b. Signature and title of certifie	g Nurse Practitioner:	To the best of m	ny knowledge,	death occurred at	the time, da	ate and pla	ace, and due to	the caus	e(s) and man	ner as st	ated.	
	12		> Rahns	4			D600					ate signed (N		ay, rearj	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
			Bindu Joseph,				e, Rocky	/ille,	MD	20850					
	Stat		31. Date filed (Month, Day, Year)	2012 3 Rec	gistrar's Signa	ure	Red.								

		. For	Please	e Type or State of		Black Ir					-		•	ble.		
		<ul><li>State Registrar</li></ul>				Cer	tificate	of D	eath			Reg. N	10. 20	12	181	4 3
Physicia		1. Decedent's Name Noe Jos		,							2. Date of De May 1		<sup>0ay</sup> 2012	Year	3. Time of Death 9:03 p	
Medic Examin		4a. Facility Name (if	not institution, giv	e street and numb	ber)		4b. City, To						c. County of			_
Funeral		Holy Cr  5. Social Security Nu	oss Hosp		7. Age (In yrs.	last birthday)	Sil If Under 1		Spri		8. Date of Bi	rth		ntgo	nery place (State or Fore	ian
Director		None		1 🍱 M 2 🗆 F	r .go (m yro	O Yrs.		Days	Hours 3	Min.	(Month, Day 14	ay, Year)		Coun		ign
at at	or	Usual Residence of 10a. State	of Decedent 10b. County		10c. Ci	ty, Town or Loc	cation		3	))	May 14	, 20	712	MD 1	0d. Inside City Lim	its
Maryla 28a-f s otified	irect	MD	Mo	ntgomery		Silver	Spri	ng							1 🗌 Yes 2 🛭	No
ith the	Funeral Director	10e. Street and Num	nber y <b>don Cou</b> :	mt Ant		-	10f. Zip C		0.1				Citizen of Wh	nat Cour	itry?	
eath w	Fune	11. Marital Status	ydon cou.	12. Was Deced	lent Ever in U.	S. 13. V	Vas Deceden	209 at of His		gin? (Spe	cify Yes or No- Rican, etc.)		USA 14. Race -			
ırs after d ıral", or i I Examin	þ	1 🙀 Never Marri 3 □ Widowed	ied 2	Armed Ford  1  Yes  If Yes, Give  Year or Dat	2 🛚 No						radorea		Black, Specify:	White, o	ite	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spec	15. Decedent's ecify only highest gondary (0-12)		4 or 5+)	(Give F	lent's Usual ( kind of work ( O NOT use re	done du		t of worki	ng	16b.	Kind of Bus	iness/Inc	dustry	
ad with Hygien other ti	Be C	None 17. Father's Name (F				N,	/ A		10 Math	nula Mana	e (First, Middle	Majda	N/A			
d be file Jental Jerked c	Tol		e Zuniga		1				Sind	_		, iviaidei	n Surname)			
should and N		19a. Informant's Na				1					l Route Numb					
I and 2 I Healtl Item 2: other t		Jose Noe 20a. Method of Disp		Cabrera/	20b. I	Place of Dispo	sition (Name	of	- :		ot. 5,S Date		r Spri Location - C		MD 20901	
t. Page tment o rtant: If njury or		4 Donation	Cremation 3 [ 5 Other (Spec	cify)	Jiaic	cemetery, cren e of He	eaven	Ceme	etery		$2^{1}_{012}$ ,	Sil	Lver S	pri	ng, MD	
permi Depar Impor any ir		21. Signature of Fur	neral/Service Licer	ise):		<b>F</b> 3	ancars O Uni	Adgress vers	ctu city	ins Blvd	Funera	1 Hc Silv	ome In ver Sp	c. ring	g, MD 209	01
Physician/ Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	rt failure. List only Final	a. Hypol	astic or as a conseq	Lungs		of dying,	, such as o	cardiac d	or respiratory a	rrest,			Approximate Interval Between Onset and Death 3 hrs. 55	
	cal Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	nmediate rlying injury s	Due to (c	or as a conseq	pruptio									3 hrs. 5 mins 3 hrs. 55 mi	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial free.	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2 0 9 Unknown	months?		lirth 2 Tet ant at time of	al death 3 🗌	Ectopic pre Other (spec						23d. Date Mont		ery Day <b>Y</b> ear	
s that t gned b	ρ	Part II. Other signifi					nderlyin <b>g</b> cau	use give	n in Part I	l.	23e. Did	tobacco	use contrib	ute to th	e cause of death?	
w require s been si 2 should	Completed	Prolonge	ed_Ruptu	re of Me	mbranes	5					24a. Was	an	24b. We	ere auto	pably 4 X Unkno	ole
The la	Com										auto perf 1 🗌 Yes	ormed?	de	ath?	mpletion of cause o 2 □ No	ΣT
Physician: T this certifica ral director, p	Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑		Hospital:				Lau			only one)					
g Physer this	te: To	27. Manner of Death	h	28a. Date o		28b. Time of		. Injury	4 L Nu at		me 5 Res 28d. Describe					
tendin death. tor; Aft the fur	Certificate:	1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigation 6 ☐ Could not	on be		injury	М		es 2 🗌							
ital or A		4  Homicide	determined	buildin	g, etc. (Specif						City or To	wn, Stat	te)		Route Number,	
the Hosp nin 24 hou the Fune	Medical	(Check 2	☐ Certifying Ph☐ Medical Exar☐ Certifying Nu	niner: On the basis	s of examinatic	n and/or invest	igation, in my	opinion	, death oc	curred at	the time, date	and place	ce, and due t	o the cau	use(s) and manner st	tated
Note that the second of the se		29b. Signature and t	title of certifier	Caita	t 1	UD PL		D66	number 134				ate signed (			
		30. Name and addre	ess of person who the G. Ga	completed cause	of death (Item			: G1	en R	oad,	Silve	r Sp	ring,	MD	20910	

Registrar

State

31. Date filed (Month, Day, Year) NAY 21 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 May LLOYD **ELLIS SNYDER** 3:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Months Days Hours Director 218-38-7367 1 X M 2 - F 72 May 10, 1940 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at the Maryland Director must be notified 28a-f 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a with 1900 Rosemont Avenue 21702 U.S.A. items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 20 1 Yes 2 X No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Contractor Painting event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental | ပ Forest Snyder Mattie Bell Harner traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Joan Ann Snyder - Sister-In-Law 1220 Florence Road, Mount Airy, Maryland 21771 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or conce. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/19/12 Metropolitan Crematorium Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Sign ture of uneral Servic Ficens 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tun disease or condition Medical resulting in death) sequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death
Unknown signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural Accident (Month, Day, Year) 5 Pending work 1 Yes 2 No Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occored at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death within 2 To the F only one occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar DHMH 17 Rev 06-2011

State

Robert L. Kaufmann,

8

31. Date filed (Month, Day, Year)

M'.D.

Registrar's Signature

300 West Nineth Street, Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/15/2012 Year PRESTON GARDINER SPRING 11:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 27341 REST CIRCLE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours 220-22-5875 **Director** 1 XM 2 D F 92 01/27/1920 NEW YORK Usual Residence of Decedent shov at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f MD TALBOT 1 Yes 2 X No EASTON 10e. Street and Number 10f. Zin Code 'n 10g. Citizen of What Country? must be Funeral 23a 27341 REST CIRCLE 21601 USA ral", or items? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 

Yes 2 

No
If Yes, Give Black, White, etc. Š 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: "natural", 3 Widowed 4 X Divorced Specify: WHITE Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry MARYLAND HIGHWAY (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATION 12 HIGHWAY AGENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 ROYCE R. SPRING HARRIET DEYO 19a. Informant's Name/Relationshippersonal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 ROBIN B. HUMES/ REPRESENTATIVE 20 DEER PATH UNIT #1 MAYNARD, MA 01754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o CHESAPEARE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/17/2012 STEVENSVILLE, MD 21. Signature of F. Tral Service Licenstee PENILOWS dreft DIFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 art 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause or Interval Between Immediate Cause (Final Onset and Death Pnysician disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be of Vital Records, P.O. Box 68760 the IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ò Day Pregnant at time of death Month Year 1 | Yes 2 L 9 | Unknown the a Unknown à signed E Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform I or Attending Physician: The after death. certificate 1 Yes 2 🗌 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Natural injury 5 Pending Division Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) D47492 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7+IVARS State

State Registrar Date filed (Month PAY'et) 8 2012

32. Registrar's Signature

555 Cynwood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2012 Physician/ 6:43 A M May 18, Helen SHUMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 3200 N. Leisure World Blvd., #319 Silver Spring If Under 1 Year If Under 24 Hrs, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 216-46-9068 Virginia **Director** 1 □ M 2 X F Jan. 6, 1918 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County Director Silver Spring notified Montgomery Maryland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ems 23a or r must be r Funeral United States 20906 3200 N. Leisure World Blvd., #319 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. white Armed Forces? jo, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 🕅 Widowed 4 🗆 Divorced "natural" Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha Nursing Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. ပ Jennie Bonner Louis Ronick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip 694) 8 Sweetwater Drive, West River, MD 20778 Charles Shuman, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 05/21712 cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA King David Memorial Garden Signature of Furtera Service License Torchinsky Hebrew Funeral Home NW, Washington, 20012 254 Carroll St., 23a. Part Eprer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Years <u>Essential Hypertension</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) nding physician use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes mellitus Type II, anemia, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed cerebrovascular disease 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

t

State

3 [

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Feldman, M.D.</u>

MAY 22 2012

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

only one)

Burt

DHMH 17 Rev 06-2011

Registrar

29c. License number

D 23958

3305 N. Leisure World Blvd., Silver Spring, MD

29d. Date signed (Month,

May 18, 2012

20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 05720/2012 9:30 A M Andrew Bart Steinberg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5 West Lenox Street Chevy Chase Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Director 1 🗷 M 2 🗆 F 124 54 6997 Yrs 53 10/12/1958 New Jersey Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director MD 1 X Yes 2 No Montgomery Chevy Chase 0 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 5 West Lenox Street must | 20815 United States items Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iter 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give Specify ad 2 should be filed within 72 hours an leath and Mental Hygiene.
Im 27 is marked other than "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mollie Deustch Irwin Ira Steinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Roxann Maria Steinberg / Spouse 5 West Lenox Street Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lower City Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 105/24/2012 Falls Village, CT 4 ☐ Donation \_5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Years Physician/ disease or condition resulting in death) Metastatic Uveal Melanoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) for in the past 12 months? Month Pregnant at time of death Day Year 2 No be detached 9 Unknown 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 💢 No director. Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury X Natural work? 1 ☐ Yes 2 ☐ No s after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, 24 hours Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Theodore C. M. Li MD

MAY 22 201

31. Date filed (Month, Day, Year

29c. License number

3301 New Mexico Ave. NW Suite 342 Washington, DC 20016

14603

29d. Date signed (Month, Day, Year)

May 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death CHARLES VÉRNON SMITH Physician/ JUNE 1,2012 4:15P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** . County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) Maryland Ju**llo**nt 16<sup>ay,</sup> 1**92**8 1 🖁 M 2 □ F 220-30-9100 83 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State notified at Director Middletown Maryland Frederick 1 Yes 2 X No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r United States 21769 Funeral 8314 Hollow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc ō þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Hygiene. other than "natura rent, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farmer alth and Mental Hygien 27 is marked other the ranmatic event, the Be 18. Mother's Name (First, Middle, Maiden, Surname)
Mary Catherine Zimmerman 17. Father's Name (First, Middle, Last, မ Guy Vernon Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8314 Hollow Road, Middletown, Maryland 21769 Lucy Smith / Wife Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 5. St. Mark's Cemetery Petersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Returney Mand Bastord PA Funeral Home, 21. Signature of Funeral Service Licenses 106 E. Church Street, Frederick, Maryland 21701 MO1473 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Houte matori disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine stuge the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months?

1 Yes 2 No ģ Day 5 Other (specify) Pregnant at time of death signed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 1 Natural 5 Pending Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  State Registrar  Certificate of Death										
1. Decedent's Name (First, Middle, Last)  Physician/ Medical  ANN C SABIN							*****	2. Date of De	eath Day	Year	3. Time of De	eath
4	Medic Examin		4a. Facility Name (if not institution, give stre		4b. City, Town, or	Location of Dea	1 JUNE 2	2012 4c. County 6	of Death	2:45A	IVI	
	Formand		FREDERICK MEMORIAL  5. Social Security Number   6. Sex	HOSPITAL  7. Age (In yrs. la.)	st hirthday)	FREDERI(	CK I If Under 24 Hr	s. 8. Date of Bir	FREDE			
	Funeral Director		578-22-4794 Usual Residence of Decedent	1 2¥ F 86	Yrs.	Months Days	Hours Mir		v. Year)	Country	ice (State or F York	oreign
	he Maryland or 28a-f show notified at	Director	Maryland Montgomer		Town or Local Reville					100	d. Inside City	
	n with the	Funeral D	10e. Street and Number 3812 Sloan Street			10f. Zip Code 20853	3		10g. Citizen of W United	hat Countr State	y? S	
920	e filed within 72 hours after death with the Manyland tal Hygiene. ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	11. Marital Status  1  Never Married 2  Married  3 X Widowed 4  Divorced	Was Decedent Ever in U.S. Armed Forces?  1 Yes 2X No If Yes, Give Year or Dates.	l II	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- American , White, etc Whit	o.	
15-0	72 hou n "natu fedical	Completed	15. Decedent's Educa (Specify only highest grade o		(Give F	ent's Usual Occup- aind of work done of	ation Juring most of wo	orking	16b. Kind of Bus	siness/Indu	stry	
21215-0036	Hygiene.  other than ent, the N		Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) xecutive	Assista	nt	Feder	al Go	vernme	nt
Maryland	ould be filed id Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) William Croni				18. Mother's Na Agnes		Maiden Sumame)			
Mar	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Cathy Lastner/ Daug			g Address (Street a			-	-	-	
ore,			20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆 Ren	20b. Pla	ace of Dispos	sition (Name of patory or other place	el	Date	20c. Location - 0			
Baltimore,	t. Pag tmen rtant: rjury		4 Donation 5 Other (Specify)	Gat	e of 1	Heaven	06/	06/2012	Silver			
Ba	Depar Depar Impo any ir		21. Signature of Funeral Service Licensee	MO1646	1	Name and Addres	rch St.	eeney & Frederi	Basford ck, Mary	Funer land	al Hom 21701	ie
posts.	Medical		23a. Part 1. Enter the disease, ocomplicate shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ions that caused the death. ause on each line.  Due to (or as a conseque	agg	r the mode of dying		c or respiratory an	rest,	lr.	pproximate nterval Betwee Inset and Dea	
	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	/		/			_		
	ruted nd ransit	Examine	cause. Enter Underlying Cause (Disease or Injury that initiated events	С								
0	e be executed ysician and ne burial-transit	ical E)	resulting in death) Last	Due to (or as a conseque	ence of):							
928	rtificate ing phy e as the	Med	IF FEMALE:				-		100			
). Box 68760	To the Propriat or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transt	Physician/Medical	in the past 12 months?	If yes, outcome of pregnand  1 ☐ Live Birth 2 ☐ Fetal  4 ☐ Pregnant at time of de  9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	у		23d. Date Mont	of delivery th Da	ay Year	r
ds, P.O.	requires that the been signed be should be detailed.	ρ	Part II. Other significant conditions contrib		ting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contrib Yes 2 No 3			
Division of Vital Records,	Physician: The law requirthis certificate has been sral director, page 2 should	Completed	Appertension	<b>V</b>				24a. Was a autop perfo 1 \sum Yes	osv pr		findings avai letion of caus	
/ital	/sician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hosp	ital: 1 <b>X</b> Inpatient 2 □ E	R/Outpotion	Cu	r:					
of	ing Phy		27. Manner of Death  1 Natural 5 Pending		8b. Time of injury	28c, Injury	at		lence 6 Other ow injury occurred			
isior	Attend er death ector: A by the f	Certificate:	2 Accident Investigation	8e. Place of Injury - At hom	ne, farm, stre		Yes 2 No		itreet and Number	or Rural Ro	oute Number,	
<u>≥</u>	pital or ours afte eral Dir filled in			building, etc. (Specify)				City or Tow				
	I to the Nospital or Attending Phy within 24 hours after death.  To the Funeral Director After thi completely filled in by the funeral	Medical	only one) 3 Certifying Nurse Pr	a: To the best of my knowled On the basis of examination a actitioner: To the best of my	and/or investi	gation, in my opinio	n, death occurred	at the time, date a	nd place, and due t	o the cause	(s) and manne ed.	r stated.
	0 1 with		29b. Signature and title of certifier			29c. License	number 643		29d. Date signed (	Month, Day	(, Year)	
			30. Name and address of person who comp	-i 00 - G	(Type, Pr	int)	3 13	-TL	7-7	Free	Venas	
	Stat	-	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	<u>う</u> C	190n	nas >	J hons.	en th	~	10 412	702
	Registra	r	JUN 0 7 20	IK Denous	1. 1	backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sally Madeline Strouth MA 0503 9019 Medical won 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year I If Under 24 Hrs 8. Date of Birth (Month, Day, Year **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Director** 225-48-4245 1 M 2 X F West Virginia Aug.20,1938 73 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. Count 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Smi thsburg Washington Md. 1 X Yes 2 No 10f. Zip Code 21783 10e. Street and Number 10q. Citizen of What Country? 13 Maple-Grove Ct. U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hardware Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Linda E. Sartin Albert H. Sifers permit, Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13349 Greensburg Rd. Smithsburg, Md. 21783 Anne K. Strouth(Daughter-in-Lawl) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Pat 2. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Md. 2012 . Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death **Physician** disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Day Year Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy within 24 hours after death.

To the Funeral Director, After this certificate I 1 Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of eertifier 0054451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonham 2911 Tefterson

DHMH 17 Rev 06-2011

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $20\overset{\scriptscriptstyle{\mathrm{Year}}}{2}$ Lucille Toms May Medical . 13 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1427 West Church Street Hagerstown <u>Washington</u> Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Days Min. (Month, Day, Year) Hours Country) Director 1 □ M 2 🏋 F 220-16**-**6806 86 Usual Residence of Decedent 12/08/1925 West Virginia 28a-f show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown ö 10e. Street and Numbe 10f. Zip Code must be 10g. Citizen of What Country? 23a Funeral 1427 West Church Street 21740 U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner 6 þ 1 Never Married 2X Married 1 Yes If Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Purchasing truck Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental 2 Harry Elmer Griffith Lucy Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Toms / Husband 1427 West Church St. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 05/29/2012 Hagerstown, Maryland re of Funeral Societice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician disease or condition resulting in death) Utering Canco mouth Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the common statement of the c IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) After this funeral ( 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director, At completely filled in by the fu 2 Accident 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson DY 200 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup>2012 RAYMOND LYNWOOD TOLLEY JÜNE 12:40P 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 216-50-4570 Days Hours Min **Director** 1 🕅 M 2 □ F 63 Sept.19,1948 Virginia Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland Frederick 1 Yes 2 No Myersville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funera 13 Harp Place 21773 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Yes 2 X No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Painting Contractor Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Robert Hughes Tolley Hazel Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Tolley/wife 13 Harp Place, Myersville, Maryland 21773 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory Jun 4, 2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature 504 Main Street 22. Name and Address of Facility Myersville, MD 21773 Ricketts Funeral Home 23a. Part 1. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 1 Yes 2 No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 12 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After Natural 5 Pending the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 17, 2012 Mahin Tondari 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 15302 Diamond Cove Terrace Rockville If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) May 11, 1927 1 🗆 M 2 🔀 F **Director** Tehran 215-96-9887 85 Usual Residence of Decedent 28a-f show 10a, State 10c. City. Town or Location 10d. Inside City Limits with the Maryland be notified at Director MD Montgomery Rockville 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 15302 Diamond Cove Terrace U.S.A. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha the Own Home 7 Home Maker Be 17. Father's Name (First, Middle, Last, 18 Mother's Name (First Middle Maiden Surname) ပ္ Bibi Shikholislam Asadolah Arbabi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15302 Diamond Cove Terrace Rockville, MD 20850 Astiagh Tondari - Son Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State National Memorial Park Falls Church, VA 5/23/2012 4 Donation 5 Other (Specify) nature of Funeral Servi m Ø 1598 22. Name and Address of Facility National Funeral Home 7482 Lee Hwy., Falls Church, VA 22042 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATHEROSCHERCHO 2243H Medical **Examiner** ENTRICOLAR WITH MINE 1 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown Month Day Year the ; g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No Yes 2 X No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician 29a. Certifier the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 completely fi Medical Examiner: O basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the F the only one) Certifying Jurse Pract ner: To the best of my kn edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Hee51280 5-18-2012. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar-Dehkordi, M.D. 10110 Molecular Dr; Rockville, MD 20850

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

MAY 22 2012

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 25 8:20 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min. 212-24-6053 Director 1 **X** M 2 □ F 83 Aug. 18,1928 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Completed by Funeral Director items 23a or 28a-f Hagerstown 1 Yes 2 No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b any injury or other traumatic. 21740 USA 143 King Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give white 1947-50 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) transportation 10 truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Jennings Vinson, Sr. Idella Worthington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1226 Potomac Ave., Hagerstown, Maryland 21742 19a. Informant's Name/Relationship (Type, Print) Julie Vinson - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory | 5/30/12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME Hagerstown, Maryland 21740 Wilson Blvd. 415 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Se wentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Dav Year Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 5 Pending of thours after death.

E Funeral Director: A sletely filled in by the filled in the f Acciden
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continued Freditioner: To the best of my movinedge death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complet only one) 29c. License number 29d. Date signed (Month, Day, Year) RICHARD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vet-1 Antietam St., #306 State

DHMH 17 Rev 06-2011

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan		artment <i>rtificate</i>			and Me	, ,	2	012	10155
			Registrar  1. Decedent's Name (First, Middle, Last)	)	Cer	uncate	OI DE	eauri		2. Date of Deat	eg. No h	<u>U12</u>	3. Time of Death
	Physicia Medic		Dan Wilson Wagner							Month	17 <sup>Day</sup>	$20\overset{\text{Year}}{12}$	7:30 A M
-	Examir		4a. Facility Name (if not institution, give s	treet and number)		4b. City, To	own, or L	ocation of	f Death		4c. Cou	inty of Death	
1			578 Mt. Zoar Road					wing				Cecil	
	Funeral Director		5. Social Security Number 6. Sex 218-32-5687 1	7. Age (In yrs. In <b>76</b>	•	If Under 1 Months	Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day,		9. Birth Cour	place (State or Foreign htry)
		1	Usual Residence of Decedent	70 / V	Yrs.					4/22/19	936		TN
	f show	호	10a. State 10b. County	10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mar. 28a-	Director	MD Cecil		Conowi								1 Yes 2 XNo
	ith the	宣	10e. Street and Number			10f. Zip (				1		of What Cou	ntry?
	ems 2	Funeral	578 Mt. Zoar Road	12. Was Decedent Ever in U.S	S. 13. V		2191		in? (Specif	v Yes or No-		JSA Race - Ameri	can Indian
9	ter de or its	by F	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1   Yes 2 □ No					Puerto Rio	y Yes or No- can, etc.)		Black, White,	
003	urs af ural", al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	1 🗌 Yes 2	XX No	Specify:			Spec	cify: W	hite
21215-0036	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad		(Give I	dent's Usual kind of work	done dur	ion ring most o	of working		16b. Kind o	f Business/Ir	ndustry
12	within giene. ner thar t, the M	Con	Elementary/Secondary (0-12)	College (1-4 or 5+)		o NOT use r o <b>1 Bus</b>	,	traci	tor		Schoo	ol Bus	
	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)		benot	or bub				First, Middle, M			
ylar	should be filed wit and Mental Hygie is marked other raumatic event, the	은	Roby B. Wagner Sr.					Far	nnie	K. Mil:	ler		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (S	Street and	d Number	r or Rural F	Route Number,	City or Town	n, State, Zip	Code)
	and 2 s Health tem 27		Emma Wagner - wife  20a. Method of Disposition		578 Nace of Dispo			oad,		wingo,			
Baltimore,	~ O +- 1-		1   Burlal 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	emetery, cren	natory or oth	er place)		Dat			on - City or To	
altir	手背がご。		21. Signature of Funeral Se		owingo	Bapt .  Name and	<ul><li>Cer</li><li>Address</li></ul>	n • ; 5 of Facility	7/22/2 В Т	F0ard 1	Conow	ingo,	MD PA
m	Depar Impor any ir		1/~							, Risi			
			23a. Part 1. Enter the disease, or complishock, or beart failure. List only one	oations that caused the death cause on each line.									Approximate Interval Between
-1	Trysician/		Immediate Cause (Final disease or condition	a CEREBROVASCULAR ACCIDE							T	- 1	Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a consequence of):  EAILURE TO THRIVE									
	and the	ner	oequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	10	11			1 0 0 0	- 1		
)	uted	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	CANCER	OF	= $T$	HE	E	34	4 DD E	イ		
	te be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):	20 11	T	10	V Ci	CT101			
68760	physic physic the b	Physician/Medical		UNIVAR	- (	7-710			17 €				
.89	nat the death certificate ed by the attending phy detached for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnar	ncy	7 _					23d.	Date of deliv	erv
Box	death ie atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown		Ctopic prediction of the second control of t						Month	Day Year
P.O.	at the		9 Unknown  Part II. Other significant conditions con		ulting in the u	ndorlying on	uso civon	in Bort I		00 0000			
S, P,	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	d by	RIGHT ABOL	IE KNEE	AM	PUT	AT	700	$\sqrt{}$				he cause of death? bably 4 Unknown
ord	requires the been signer should be	Completed	STALF 4 PK	ESSURF 1	110	ED	10	00	UX	24a. Was an			psy findings available
ec	The law ate has page 2	omp	CARANDRY A	IN TER 11 D	15=1	LE	<u></u>			autopsy perform 1 Yes 2	v	prior to co death?	impletion of cause of
alF	ician: The certificate rector, pag	BeC	25. Was case referred to medical	10,000	1-67	100	26. Place	e of Death	n (Check or		No!	1 Yes	2 LI No
Z.	hysici his ce Il direc	유	I LI Yes 2 LX No	ospital: 1  lnpatient 2 :	ER/Outpatien	it 3 🗆 DOA	Other:	4 🗌 Nurs	sing Home	5 AResider	nce 6 $\square$ C	ther (Specify	()
اه ر	iing P .r After t funera	Certificate:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		. Injury a work?	_	- 1	d. Describe how	w injury occ	urred	
Sior	death death ctor: /	rific	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ne farm stre	M eet factory o		es 2 🗆 N	$\rightarrow$	f Location /Str	and Num	mbor or Burn	l Route Number,
Division of Vital Records,	al or A s after Il Dire ed in b		4 ☐ Homicide determined	building, etc. (Specify)		ot, idotory, c	Since		20	City or Town,		riber or nurai	noute Number,
_ [	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 ertifying Physic (Check 2 Medical Examine	cian: To the best of my knowledger: On the basis of examination	edge, death o	occurred at the	he time, c	date and p	place, and	due to the caus	se(s) and ma	anner as stat	ed.
	thin 2, the F mplet	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of m	y knowledge,	death occurr	red at the	time, date	and place	, and due to the	cause(s) an	d manner as	stated.
	5 7 8 A		255. Signature and the or certifier	,		D	icense ni	44L	6	29	5 / C	ned (Month,	Day, Year)
			30. Name and address of person who col	mpleted cause of death (Item	23a) (Type, P	rint)	- i	, 00			110	112	
10	TIVA		CORNELIUS .	DOE, MO	14	ROGE		RI	0#	211 NO	DRTH	EAST	11021901
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ire A.	back	/						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month 18<sup>0ay</sup> Physician/ 2012 John Wierzbicki 0804  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Ceci1 110 Woodcrest Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** AUG 25, 1942 Months Days Hours Min 1 X M 2 D F Delaware 69 Yrs. Director 221-26-4844 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 United States 110 Woodcrest Drive 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Cleaning Owner Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Linda Fusco Edward Wierzbicki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 110 Woodcrest Drive, Elkton, MD Vickie Stebbins/Fiancée 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silverbrook Crematory 2012 Wilmington, DE 22. Name and Address of Facility Hicks Home for Funerals, P.A. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ LUN6 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a pur secuence on Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other si<mark>gnificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify 2 10 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHWAWA 2 33 SUITE A, CHESAPEAKE CITY, MD21915 HERMAN ITW 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 May 16, Sarah Thomas Want 4:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8: Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Hours Jan. 3, 1927 85 **Director** 223-30-2137 Virginia Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location or items 23a or 28a-f sho miner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🌠 No Maryland Montgomery Gaithersburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23761 Rolling Fork Way 20882 U.S.A. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be William Taylor Thomas Madeline Compher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elliotte C. Want, Jr. - Son 23761 Rolling Fork Way, Gaithersburg, Maryland Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 4 Donation 5 Other (Specify) May 21, 2012 Leesburg, Virginia 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signa ure of F) neral Service Censee Roverl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Acute temas Physician/ parcetal disease or condition resulting in death) Medical Due to (or as a consequence 0: **Examiner** Sequentially list conditions, Examiner mD Tue to Lines a consequence of: cause. Enter Underlying nding physician and use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ atten in the past 12 months? signed by the atte Pregnant at time of death Month Day 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ castee Division of Vital Records, 2 I No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was an has autopsy After this certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical exampler?

1 Yes 2 No Physician: Be 26. Place of Death (Check only one) Hospital: Other မ 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred • To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending injury 5/13/12 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number 4 Homicide determined the Gucanter Nened Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) May 17, 2012 D04115

Registrar

DHMH 17 Rev 7/2009

5

State

201 Russell Avenue, Gaithersburg, Maryland

20879

30. Name and address of person who completed cause of death (Item 23a) (type, Print)

M.D.

32. Registrar's Signature

Robert Birschbach,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 201<sup>Yea</sup> Cornelius Willard Wilson, Jr. May 0530 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🕱 M 2 🗆 F Jan. 16,1934 Hours Mary land Director 214-30-4578 78 Usual Residence of Decedent or 28a-f show notified at show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Port Deposit 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 21904 166 Remington Road U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🗵 Yes 2 🗌 No Black, White, etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates 1954-62 1 ☐ Yes 2 X No Specify: 'natural", 3 ☑ Widowed 4 ☐ Divorced Completed Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground Elementary/Seconday (0-12) College (1-4 or 5+) Artillery Repairman Twelve Years Aberdeen, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 be Cornelius Willard Wilson, Sr. Marian Meck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Marian Elaine Eures 166 Remington Road, Port Deposit, Maryland 21904 other fimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or Brookview Cemetery 05/06/12 Rising Sun, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GROSS HEMATURIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner URINARY TRACT INPECTION Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No Ö requires that the á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBELLAR TUMOR Records, 1 Yes 2 No 3 Probably 4 Unknown DIAGETES MELLITUS, HIE 2 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an CHRONIC KIDNEY DISENCE, STAGE III performe certificate l 2 No Yes 2 No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Monatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ð 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending injury 5 Pending Division 2 ☐ Accident 3 ☐ Suicide Investigation 1 Yes 2 No I Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours 1 McCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at stated. (Check 29b. Signature and title of certifier Ander Novaliand. DO\$096 MAY 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULPORD AVE BELAIR, MD 21014 4+IVA ANDREW NOW AKOUSKI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/  $P^{\mathsf{M}}$ Ward Thaddeus J. 2012 1:40 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall Charlotte Hall Veterans Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 8, Date of Birth Country)

Sw Jersey **Funeral** Days Hours Min. (Month, Day, Year) 06/02/1925 1 🔀 M 2 □ F 86 363-26-3692 New Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2X No St. Mary's Charlotte Hall Maryland 10g, Citizen of What Country? 10e, Street and Number Funeral USA 29449 Charlotte Hall Road 20622 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <sup>Specify:</sup> White Completed 3 ▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Navy Commander Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 <u>Mary Aronowitz</u> <u>Thaddeus John Ward, Sr</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gwen L. Cordner/Daughter Ocean City, MD 21843 Box 4344 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem 5/25/2012 Charlotte Hall, MD 21. Signa refof Funeral Service Licen le 22. Name and Address of FacilityBrinsfield-Echols Funeral Home, P.A. M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to hume date cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ , dro cephflus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

MAY 29

AVA

Stephen Patrick Cafferty 100 Hosptial Road Prince Frederick, MD 20678

ees of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death 1. Deçedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 11:30AM ETCHER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 4020 Solomons Island Road Harwood Social Security Numbe 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 79 Months Days Hours Min. 212-34-0061 **Director** 1 M 2 F 12/28/1932 Baltimore, MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel MD Harwood 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20776 4020 Solomons Island Road USA within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue: Armed Forces?

1 Ayes 2 No. 55-60 11. Marital Status 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. 1X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates. Specify: 3 - Widowed 4 - Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Lawyer Elementary/Secondary (0-12) College (1-4 or 5+) Law 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Emily Hammond John Fletcher Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4024 Solomons Island Road Harwood, MD 20776 Christopher Wilson Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/2014 Glen Burnie MD Atlantic Crematory 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 21. Signature of Funeral Service Licen Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1205 JUKNOW N disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence off: cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.
within 124 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn and the surface of the pure pure the pure that the pure Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ပ 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗆 Yes 2 🗆 No Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 12 5 18 MP 0003658 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RSH 445 Defense Highway Annapolis, MD 21401 Fegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward L. Wachter May Medical 3:20a M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Dec. 28 9. Birthplace (State or Foreign 1 X M 2 □ F Year) 19<u>25</u> Months Davs Hours Min 216-22-7717 Director 86 Dec. Maryland Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified Maryland 1 Yes 2 No Frederick Frederick 5 10e. Street and Numbe 10f Zin Code 10g. Citizen of What Country? 23a Funeral 10610 Lenhart Road 21702 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces ō à 1 Never Married 2 X Married ☐ Yes 2 🛛 No 72 hours after 1 ☐ Yes 2 🖾 No Specify. If Yes, Give "natural" 3 Widowed 4 Divorced Completed Specify: Year or Dates White Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Repair/Test Desk Man C&P Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည Leslie D. Wachter Margaret E. Carmack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Wachter/ Wife 10610 Lenhart Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Olivet Cemetery 5/21/2012 Frederick, Maryland. 21. Signatu uneral Service Lic inse Name and Address of Facility tauffer Funeral 621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 27 Months disease or condition resulting in death) Metastatic Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Dav Year the 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of autopsy perform death? Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕱 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \overline{\mathbf{X}}$  Other (Specify)  $\overline{\mathbf{Hospice}}$ 

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate eral Director: After this certific filled in by the funeral director, 24 hours

Maryland 21215-0036

Baltimore,

-	ō	
	01	
	1	

State

Registrar

Certificate:

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 46 Thomas Johnson Drive Ste 200 Frederick, Marland 21702 Kanan Hudhud

5 Pending

Investigation

determined

6 Could not be

27. Manner of Death

1 X Natural

☐ Accident ☐ Suicide

4 Homicide

29a. Certifier

(Check

31. Date filed (Month

29b. Signature and title of certifie

32. Registrar's Signature

28a. Date of injury

(Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

m

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

D41866

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

May 18, 2012

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1405M Elmer David Wyand Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Hagerstown Washington Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 1 X M 2 D F 220-34-0214 74 Dec.26, 1937 Maryland Usual Residence of Deced or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at s 23a or zo.. must be notified a' **Funeral Director** 1 X Yes 2 No Maryland Washington Williamsport 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must ! 18 Springfield Lane 21795 USA r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Communications other Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked o traumatic eve ပ Pauline Edna Leo Wyand Easterday Elmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 18 Springfield Lane Williamsport, Maryland Martha J. Wyand - Wife item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of F Important: If ite any injury or ot once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Denation 5 X Other Specify Entarbment Cedar Lawn Mem. Park May 26,2012 Hagerstown, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. ature 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHERUSCLEROTIC disease or condition resulting in death) HEART DISEASE Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to jor as a consuluence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for Dav

Physician/ Medical **Examiner** 

the Maryland

with

Page 1 and 2 should be filed within 72 hours after death

Health

Baltimore, Maryland 21215-0036

physician and s the burial-trans detached signed by page 2 should neec Jas funeral director, After this 24 hours after death. Funeral Director: A th. þ

Completed by

Be

မ

Certificate:

Medical

29b. Signature and title of certif

MAHESH

Hospital o Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nhknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State, rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitiongr: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

29c. License number

20061411

GER

29d. Date signed (Month. Day, Year)

12 D

CAMPUS

2012

DHMH 17 Rev 06-2011

Registrar

within 2 To the I

T10-5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /// / //FUICAL

gistrar's Signature

KRISHNAMOORTHY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALICE LEE WRIGHT Month 2012 8:45 May  $P_M$ 17 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 218-10-0712 Days Hours **Director** 1 M 2 F 91 Sept. 19,1920 Maryland Usual Residence of Decedent 28a-f show 10b. Count 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 208 Russell Ave. 20877 United States or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important, If item 27 is marked any injury or other traumation once. William L. Armiger Alice Lee Disney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Elizabeth Wright(Daughter) 208 Russell Ave. Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 21. Signature of Furgeral Service Lizer 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 (M01116)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ Minutes Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) use as the burialnding physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year signed by the at be detached for 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 performe death? Yes 2 X No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital မ 1 ☐ Yes 2 💢 No Other: 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1X Natural (Month, Day, Year) 5 Pending Division 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D33261 May 17, 2012 30. Name and address of person who completed cause of death (Item 23a (Type, Print) 9901 Médical Center Dr. Dr. William Dooley M.D. Rockville, MD 20850 31. Date filed (Month, Day, Year) State

Registrar

MAY 22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elva May Yeager May 17, 2012 1:05 PM M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Overlea Health & Rehabilitation Ctr. Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 088-14-3070 89 1 □ M 2 F **Director** Sept. 3, 1922 Maryland Usual Residence of Decedent or 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 1724 Aberdeen Road 21234 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 9 1 Never Married 2 Married Black, White, etc. Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Early Esther Wetzel 19a. Informant's Name/Relationship (Type, Print) Mrs. Brenda Y. Young, daughter 19b Mailing Address (Street and Number or Bural Route Number, City or Town, State Zip Code) 6803 Crest Circle, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of May 24ate 2012 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery May 24, 3012 Frederick, MD 4 Donation 5 Other (Specify) Signatur of Funeral Service Lic <sup>2</sup>Keeney<sup>Ad</sup>and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pumon ∠Ph<sub>y</sub>sician Medical Examiner Sequentially list conditions Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Live Grant Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury . Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending iniury work Investigation Accident 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur of person who completed cause of death (Item 23a) (Type. Print) 9 5601-Loch egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistramEND#8perFH, 5/24/12; BMW, MoCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sylvestic Yorrick Month 4:55 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner of Maryland Modical Center Balhnore, Maryland Balhmare Chy If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours (Month, 28 Year) Min 579-64-9836 1 **X** M 2 □ F Director 71 10/20/1940 Guyana Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Silver Spring Montgomery Maryland o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20904 3120 Castleleigh Road U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or.i þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify "natural", Completed 3 Widowed 4 Divorced Black other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government 5+ Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ Harriet Thompson Survester Yorrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3120 Castleleigh Road, Silver Spring, Maryland 2090# Marjorie Antonio-Yorrick/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Rg Gate of Heaven Cem. 05/25/2012 | Silver Spring, MD 4 Donation 5 Other (Specify) 21. Sign 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Acute Myelogenous disease or condition resulting in death) years Medical Due to (or as a cons A uence of **Examiner** fraumo ma Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician a page 2 should be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Tes 2 No the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita Other: 1 🗌 Yes ပ္ 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at wo<u>r</u>k? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Natural Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Smpletely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Wedical Examiner. On the pasts of examined at the disconsection of the cause (s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 05,16,2012 1657670011

DHMH 17 Rev 06-2011

State Registrar South Greene St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Bricke

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3:00a M Yameen Zubairi Medical May 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/22/1936 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 75 Director 395-46-6203 1 🗆 M 2 🔀 F India ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Md. Montgomery Potomac 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10911 Chandler Rd. 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: asian "natural", 3 🗌 Widowed 4 🗌 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Professor 5 +University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yusuf Zubairi Razia Sultana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1255 Kenmore Dr. Great Falls, VA 22066 Rahel Zubairi-20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland National 5/16/12 4 Donation 5 Other (Specify) Laurel, Md. 22. Name and Address of Facility Universal Mortuary 411 Kennedy St NW Washington, DC 21. Signature of Funeral Service Licensee

Karly Ma 411 Kennedy 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Cerebrovascular accident Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or de a consequence on): attending physician and I for use as the burial transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Myocardial Infarction 1 Tes 2 No 3 Probably 4 V Unknown Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: Certificate: To within 24 hours after deau.

To the Funeral Director: After this of a standard filled in by the funeral di 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D67986 5/15/2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuneug Li, 8600 Old Georgetown Rd. Bethesda, Md. 20814 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 22 2012

DHMH 17 Rev 06-2011

Registrar

ameen

Dair

3

N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Adkins Sr. Day Year Physician/ Month Walter Charles 12:08 PM 7017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 917 Homberg Avenue Baltimore Essex Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min Days Hours 212-34-0477 **Director** 1**XX**M 2 ☐ F 74 01/18/1938 Maryland Usual Residence of Dece 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n must be by Funeral 23a 917 Homberg Avenue 21221 U.S.A. iral", or items ? Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 X Married 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Korea 'natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Utilities 11 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Irene Loretta Hagan William George Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 Homberg Avenue, Baltimore, Maryland 21221 item 27 Janice Lee Adkins (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 06/08/2012 Baltimore, Maryland <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death neart failure. List only one cause on each line ENd-Stage Parkinsons Immediate Cause (Final dis se or condition Physician/ dis se or conciling in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or Injury been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident M Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier usilas apalne D0057465 617/12 S203 Balhmore MOZ1209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AV NS Rajupaksemb 31. Date filed (Month; Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 22 Day WILLIAM DAY 201°2 4:34 рм Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 15812 Joyce Lane Laurel Prince George's Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Months Hours (Month, Day, Director 216-22-0862 1 X M 2 A F 84 1927 July 10, West Virginia Usual Residence of Deceden or 28a-f show notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2x No Prince George Laurel 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be r Funeral 23a 15812 Joyce Lane 20707 USA and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

★★★ Yes 2 □ No 1945-Black, White, etc by ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", 3 Widowed 4 ☐ Divorced 1946 Specify: Completed Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Customer Service Rep. Health and Mental Hygier tem 27 is marked other ther traumatic event, the Furniture Co. Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ျ C. William Ancell Mary V. McClair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank W. Giambrone/ friend 15812 Joyce Lane, Laurel, MD other 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or other 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 2012 Ivy Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. to kein? M01053 313 Talbott Ave., Laurel, MD 20707 Pad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition renal failure Medical resulting in death) Due to (or as a consequence of): **Examiner** conjestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown g Unknown Division of Vital Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2xxx No Yes XX No Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certific. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 C Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 2

JUN 0 8 2012 Registrar

Martin Weltz, MD, 4525 Greenway Ct.Dr., Greenbelt, MD 20770 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

(Check

only one)

3

29b. Signature and title of certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

May 23, 2012

29c. License numbe

D23743

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 12:46AM WILLIAM ROBERT ALEXANDER 2017 Médical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) JAN 10 1920 Months Director 578-34-0582 1 **X** M 2 □ F 92 WASHINGTON, DC Usual Residence of Decedent 28a-f shov 10a. State 10b. Count aţ 10c. City, Town or Location 10d. Inside City Limits Director notified 1X□ Yes 2 □ No MD PRINCE GEORGE'S HYATTSVILLE 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6914 PARKWOOD STREET 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö ρ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. BLACK Specify. "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12th ENGINEER GOVERNMENT traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | ဂ္ဂ CARL L. ALEXANDER LUCINDA GORHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL ALEXANDER/SON 123 57th PLACE S.E. WASHINGTON, DC of Health Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State HARMONY CEMETERY Donation 5 Other (Specify) 6/14/2012 LANDOVER, MARYLAND J. B.JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicsan/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ page 2 should be Division of Vital Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has Physician: The 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **W** No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending (Month, Day, Year) Natural 5 Pending work?
1 Yes 2 No within 24 hours after death. To the Funeral Director: A Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined building, etc. (Specify) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier License number mo who completed caus of death (Item, 28a) (Type, Print) 30. Name and address of

DHMH 17 Rev 06-2011

State

Registrar

08

park

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FRANCIS D. ALESSI June 12:55AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE NURSING HOME & HOSPITAL BALTIMORE CITY N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months Hours **X** M 2 □ F 10/9/1932 MARYLAND Director 216-30-1405 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD BALTIMORE PARKVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5 KIRWIN COURT 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. KOREA Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 Tes 2 X No Specify: Specify: WHITE 3 
Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ALESSI & ASSOCIATES Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien? 4+ YEARS PRIVATE INVESTIGATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS G. ALESSI CATHERINE M. GARVEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is JOAN ALESSI/WIFE 5 KIRWIN COURT BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 6/9/2012 CATONSVILLE, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO1139 8521 LOCH RAVEN BLVD. TOWSON. MD Pal 1. Enter the diseale, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cardiae Acute disease or condition resulting in death) one hour Medical Due to (or as a consequence of) Examiner 3 months boronary artery Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cardio my opathy Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident To the Funeral Director: / Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0093528 06-06-2012 SURAIYA BEOLUM, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE W. BELVEDERE BALTIMORE, MD -

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2012

P.O.

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ Day 9:45AM. ユップス Joseph Avon Armstead, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Glen Burnie</u> Baltimore Washington Medical Center <u>Anne</u> Arunde1 Year If Under 24 Hrs. Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-44-6043 **Director 1**XXM 2 □ F 64 8/20/1947 Baltimore, MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 ☐ Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 N. Hollins Ferry Road 21061 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married XX Yes African 1 ☐ Yes 🏋 No Specify: 3 Widowed XX Divorced Year or Dates American Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Fork Lift Driver Holeman Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Avon Armstead, Sr. Eleanor Louise Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Tera Daniels / Daugher 1225 Seminole Drive Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial XXX Cremation 3 Removal from State Atlantic Crematory 6/7/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Licensee 22. Name and Address of FacilitySingleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Cechovasia Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine lensur Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Pregnant at time of death Day been signed by the a should be detached 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform after death.

Director: After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗋 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 ss of person who completed cause of death (Item 23a) (Type, Print) ProTuni 31. Date filed (Month, Day, Ye

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUNE **FLORESE** 2012 APPLEBAUM Medical 04:47A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 213-28-8339 1 M 2 X F Yrs 83 11/11/1928 2 should be filed within 72 now. ...
It and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show ...
27 is marked other than "natural", or items 23a or 28a-f show ... 10b. County 10a, State 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE BALTIMORE 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 MARYLAND AVENUE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: Completed Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4 or 5+) MEDICAL TECHNICIAN MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN SAMORODIN LEAH HERZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau LEE APPLEBAUM/SON 521 VALLEY VIEW ROAD, MERION STATION, PA 19066 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ANSHE EMUNAH — ATTZ СНАТМ 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/06/2012 BALTIMORE, MD signature of Funeral/Service Densee 21. SOL LEVINSON & BROS., INC. MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melastalia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as signed by the attending d be detached for use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Day Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending renyaviant to within 24 hours after death.

To the Funeral Director. After this certificate has been sit completely filled in by the funeral director, page 2 should 1. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy ☐ Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) 1 ☐ Yes 2 🐼 No 卢 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) no MD D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles Sheel St 4105 Baltimore MD 21204 SYED Q. ABBMS 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ente Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Xe Siecco 1 □ M 2 🗹 F Director Usual Residence of Deceden 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tyes 2 No 0 10e. Street and Number 10f Zip Code 10q. Citizen of What Country? Funeral items 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eve 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NQT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Om Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ham State, Zip Code) 30360 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Sign, ture Funeral Service License Home, P. A. 222 MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Pnysician nterstitial Medical resulting in death) Due to (or as a consequence of): Examiner NEJMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be 2 🔀 No 1 Tes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred 1 🖎 Natural 5 Pending iniury 2 🗌 No Accident Investigation 24 hours after dea in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6/7 D64307 2012 30. Name and  $^I\!$ address of person who completed cause of death (Item 23a) (Type, Print) St. Pa VITBERL 345 21210 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of M	aryland		rtment of H tificate of D			giene Reg. No.2 (	112	18175
		,	Decedent's Name (First, Middle, in the control of the control	Last)	-				2. Date of Dea	ath		3. Time of Death
	Physicia Medic	al	FANNIE	CHERRY		BOOTH	W 60 T	Leading of Death	JUNE	3 Day 201		5:20 Р м
	Examin	er	4a. Facility Name (if not institution, g				4b. City, Town, or LANHAN		1		y of Death	GEORGE'S
	Funeral				ge (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h , Year)	9. Birthp Coun	place (State or Foreign try)
	Director		579-24-3132 Usual Residence of Decedent	1 □ M 2 🗓 F	95	Yrs.			FEB. 26	1917	NORTH	H CAROLINA
	yland f shov ed at	tor	10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits  1  Yes 2 □ No
	e Mar r 28a- notifie	Director	DC 10e. Street and Number		WA	ASHING	TON 10f. Zip Code			10g. Citizen of	What Cour	
	with th	Funeral	5207 JUST ST	REET N.E.				20019		USA	What Oodi	
	items		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- po Rican, etc.)		ce - Americ	
330	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at.	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 X  If Yes, Give  Year or Dates.	No		☐ Yes 2 🛛 No			Specif		LACK
21215-0036	hours hatur dical E	Completed	15. Decedent (Specify only highest	s Education		16a. Deced	ent's Usual Occupa ind of work done d	ition	kina	16b. Kind of I	Business/Inc	dustry
121	thin 72 ane. than *	Som	Elementary/Secondary (0-12) 12TH	College (1-4 or	5+)	life. DC	NOT use retired)			COMEDI	DATENIES.	
ס א	filed within tal Hygiene od other th event, the	Be	17. Father's Name (First, Middle, La	st)		Г	INAMOR	SUPERVI 18. Mother's Nar	ne (First, Middle,	GOVERI Maiden Surnan		
ylan	4 + 4 W	오	JOE CHER	RY				GLENNI	E HOLI	OMON		
Maryland	1 and 2 should be filed if Health and Mental Hitem 27 is marked of other traumatic ever		19a. Informant's Name/Relationship FLORENZA LAS		A		g Address (Street a				State, Zip (	
re,	ge 1 and nt of Heal ; If item; or other		20a. Method of Disposition	П		ce of Dispos	sition (Name of atory or other place		Date	20c. Location	- City or To	own, State
Baltimore,	Page 1 Iment of tant; If it jury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	ecify)	7		CEMETER	i i		ARLING	CON, V	RGINIA
Ball	permit. Page Department Important; I: any injury or		21. Signature of Funeral Service Lice	ensee			Name and Addres					HOME, INC. AND 20785
F			23a. Part 1 Enter the disease, or c shock or heart failure. List on	omplications that cause ly one cause on each lir	d the death.							Approximate Interval Between
-1	Physician/		Immediate Cause (Final disease or condition	Cardior	espira	atory					- 6	Onset and Death
10.4	Medical Examiner		resulting in death)	Due to (or as			itie					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Aspirat	a conseque	nno off:	11013					
	executed an and irial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Dysphag		200 000				_		
_	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical E	resulting in death) Last	d Date to for as	a conseque	1100 01).						
8760	tificate ng phy as the		IF FEMALE:									
89 X	death certificate be ne attending physicis ed for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1  Live Birth 4  Pregnant	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		1	ate of deliv	ery Day Year
Box	the dea y the a ached t	hysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9 Unknown		atti 5 L	Other (specify)					
о <u>.</u>	s that t gned b	by P	Part II. Other significant condition	s contributing to death	but not resul	ting in the u	nderlying cause giv	en in Part I.				ne cause of death?
rds,	equire een siç hould l	eted							7.97			bably 4 Unknown
Division of Vital Records,	sician: The law requires that the certificate has been signed by the director, page 2 should be detach	Completed by Physician/M							24a. Was autoj perfo 1 🏻 Yes	osv	prior to co death?	mpletion of cause of
a K	an: Th tificate tor, pa	Be Co	25. Was case referred to medical				26. Pla	ace of Death (Che			1 🗆 Yes	
Z	hysici his cer al direc	To E	examiner? 1 ☐ Yes 2 🖾 No		tient 2 🗆 E			4 ☐ Nursing I	Home 5 Resid	dence 6 🔀 Ot	her (Specif)	ospice Cente
n of	ding P h. After t funera	:ate:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending			8b. Time of injury	28c. Injury work M 1 🗆	rat ? Yes 2 □ No	28d. Describe h	now injury occu	rred	
SIO	Attender deat ector: by the	Certificate:	2 Accident Investiga 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of In	jury - At hom	ne, farm, stre	eet, factory, office	163 2 1110			ber or Rura	Route Number,
2	ital or urs afte ral Dir lled in				tc. (Specify)				City or Tov			
	To the Hospital or Attending Physician: "Thin 24 hours after death as after death To the Funeral Director. After this certifical completely filled in by the funeral director,	Medical	(Check 2 Medical Ex	Physician: To the best on aminer: On the basis of Nurse Practitioner: To t	examination a	and/or invest	igation, in my opinic	n, death occurred	at the time, date a	and place, and c	lue to the ca	use(s) and manner stated.
	To th To th		29b. Signature and title of certifier	1 , -			29c. License	number		29d. Date sign	ed (Month,	Day, Year)
			30. Name and address of person w	Molies	N M	20) (5: 5		38754		JUN	E 5, 2	2012
				OHESS M.D.				N.E. WAS	HINGTON	DC 200	17	
ļ	Sta Registra		31. Date filed (Month, Day, Year)  JUN 0 8		rar's Signatu							
				,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Day 2012 Breiner Jüne 8:25 p M Jean E. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Timonium Baltimore 221 Coldbrook Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 179-26-3655 Director 1 🗆 M 2 🖵 F March 2, 1935 Pennsylvania show 10c. City, Town or Location must be notified at Director 28a-f Marvland Baltimore Timonium 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with 21093 221 Coldbrook Road USA "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Menta fitem 27 is marked other traumatic e Victor Donald Fedder Mabel Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Coldbrook Road Timonium, Md. 21093 Robert W. Breiner / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Cem. 6/8/2012 Timonium, Maryland 22. Name and Address of Facility 1050 York Road Towson, Md. 21204 Ruck Towson Funeral Home, Inc. Canapp 23a. Part 1. Enter the shock, or heart e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Inal Physician/ 0 disease or condition resulting in death) Medical Division as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 moorns?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death ∐ Yes ∠ູບ □ Unknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 Yes 3 Probably 4 Unknown is certificate has been sidirector, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate has 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) s after death.

I Director: After this id in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a **To the Funeral C** filled Medical dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descripting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Bev 06-2011

Registrar

29a. Certifier (Check only one 29b. Signature, and

of certifi

30. Name and address of person who comp

ed cause of death (Item 23a) (Type, Print)

6

29c. License number

205

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

bert Blair		1 1 01 01010	ate of Maryland	d / Depa H G928	rtment of	Health Death	and h	Menta	al Hy	giene	eg. No.	20	12	181	7
Physicia		Registrar 1. Decedent's Name (First, Middl	le,Last)			_			12	Date of Dea	ath	Y. U	3.	Time of Death	
ledical Exami	31.07	ROBERT JAMES								Month June 5, 2	Day 012	Year		0145 hrs	
		4a. Facility Name (if not institution	on, give street and numb	er)	41	c. City, To	wn, or Lo	ocation of	Death		4c. C	County of E	Death		
		University Hospital				Baltimo	ore								
Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. Ia	ast birthday)	If Under		If Under	24Hrs. Min.	8. Date of Bi	972	)////// S	9. Birthp oreign	lace (State or	
Director		218-08-3096	1 <b>X</b> M 2 F	39	Yrs.	Months	Days	Hours	WIII I.	7-3-2	912		Count	try) MARYL	AND
		Usual Residence of Decedent											Į a	0d. Inside City Li	-mit-m
y any		10a. State 10b. County		10c. City,	Town or Location			_					- 1	Yes 2 📉	
aryland Sa-f sbow at once.	ō	MD.	HARFORD		]	KINGS		Æ			10- 0''	en of What			]140
Mary 28s-	Director	10e. Street and Number				10f. Zip C					i ug. Citize	n or vviiat	Couring	y r	
h the		11209 SANDYVAI						L087	0/0	-16 - Mar N	. la	USA		n Indian Black	
h with	Funeral	11. Marital Status  1 Never Married 2 X M	12. Was Deced							cify Yes or No Rican, etc.)	0-   14	White, e		n Indian, Black,	
r deat	필		1 Yes	2 X No	1	Yes 2	No.	specify:			s	pecify:	V 17	HITE	
s afte ral",	à	3 Widowed 4 Div	or Dates:	completed)	16a. Decedent	Z1	-		ind of wo	ork done		nd of Busir			
hour Exa	ompleted	Elementary/Secondary (0-12)			during mo									COUNTY	
36 hin 73 than	릛	12TH		·	MAINT	ENANO	E 1	гесн.			PUE	BLIC	LIBE	RARY	
d with	턍	17. Father's Name (First, Middle	, Last)	···	1 IMILITY					First, Middle,	Maiden S	urname)			
21215-0036 wid be filed within 72 hours Mental Hygiene. marked other than "natur c event, the Medical Exam	8	ROBERT J. B	LAIR,SR.							LSWICK		_			
21 ould b	2	19a. Informant's Name/Relations	ship (Type, Print )		i i					ural Route Nu					
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.  tem 27 is marked other than "natural", ur items 23a nr 28a-f she traumatic event, the Medical Examiner must be notified at once		SALLY UNDERWOOD	D MO	THER		209 9			RO.			CLLE,		. 21087	
Baltimore, MD 21215-0036 perm.t. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or nither traumatic event, the Medical		20a. Method of Disposition  1 Burial 2 X Cremation	n 3 Removal from		Place of Disposi crematory or oth		of ceme	etery,		Date	20¢, L¢	cation - C	ity or 10	own, State	
Baltimore, perm t. Pages I at Department of He Important: If ite injury or other to		4 Donation 5 Other S			ANTIC C					-2012				E, MD.	
ati m.t. sparm		21 Signature of Funeral Service	Licensee		<b>I</b>					MUNEK					
<b>បា</b> ខ្មីជាថា	$\Box$	23 P rt I. Enter the disease, or	NU	10 - 10	9	705 I	BELA	IR RO	DAD	NOTTI				Approximate Inte	erval
Physician /Medical		failure. List only one cause	e on each line.			e mode o	dying, s	uu as ca	i diac oi	respiratory ai	1631, 31100	r, or rear		Between Onset Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)								_	_		-		
			Due to (or as a co	orisequence c	JI).										
	힏	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence o	of):										
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	Durate (ex ex ex	onsequence (	of):			<del></del>					-		
xecuted 1 and - transit	ă	events resulting in death) Last	d.												
ੰ ਜ਼ਾਜ਼	dical	UNPENDED	AMENDED 2	8f,per	me, g928	3 6-2	5-12	sm							
- o .c.c	Ped	IF FEMALE:	23c. If yes, ou	tcome of preg	gnancy						23d.	Date of de	elivery		
68760 certificate b nding physi	an/l	23b. Was decedent pregnant in t past 12 months?	I LI ENO BITO			al death	3	Ectopic	pregnar	ncy	1	Month	Da	y Year	
Box 68760, e death certificate be the attending physic of for use as the bur	sici	1 Yes 2 No 9 Ur	nknown 9 Unknow	nt at time of d	eath 5 Oth	ner (Speci	fy)				1				
that the denet by the detached f	Physician/Me	Part II. Other significant cond			resulting in the u	nderlying	cause gi	ven in Pa	rt I.	23e. Did	tobacco u	se contrib	ute to th	e cause of death	?
ires that the signed by	Ď.	_								1 □ Y	es 2 🗸	No 3	Proba	bly 4 Unkno	wn
ords, w require s been si, should b	Completed						_			24a. Wa				ppsy findings avai	
law r has b	ם									per	opsy formed?	de	ath?	mpletion of cause	
tal Reco	Ö	OS Maria and the modic				2	6 Place	of Death (	Check o	1 Yes	2 No		<b>✓</b> Yes	2	
ital ician s certi	Be	25. Was case referred to medic examiner?	Hospital: 1 / Ing	patient 2	ER/Outpatient			Other =		g Home 5	Residen	ice 6	Other:		
n of Vi ding Physi After this funeral dir	은	1 Yes 2 No 27. Manner of Death	28a. Date of	f Injury	28b. Time of I			y at Work	?	28d. Describ		ry occurred	d		
DD C	<u>5</u>		nding Jun 4, 20	ay,Yeer) 12	1250 hrs		1 Y	es 2 🗸	No	Subject sh	ot self				
Division of Vital Records, ral ar Attending Physician: The law require raffector After this certificate has been si led in by the funeral director, page 2 should b	ica		restigation 28e. Place	of Injury - At I	home, farm, stree	et, factory,	office bu	uilding, etc	c.	28f. Location	(Street ar	nd Number	or Rura	al Route Number,	City
ital por literal in Div	Certification:	- G Suicide		Single Fa	mily Home				1	13 Belifalis	Road, Pe	myville, I	No	ls Way ttinghar	n MC
Hasp 24 hor Fune		29a. Certifier 1 CertifyIng	Physician: To the best	of my knowle	dge, death occur	red at the	time, da	te and pla	ice, and	due to the ca	use(s) and	d manner a	as state	d.	
Division of Vital Records, P.O. Box within 24 buspital at Attending Physician: The law requires that the death within 24 hours after death.  The Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for ur	Medical	one) 2 Medicai Ex	caminer: On the basis of and manner sta		and/or investigat				curred a	it the time, da					
	Ž	29b. Signature and title of certif	fier		11	77 29c.		number			1			th, Day, Year)	
2		MI			50	1/	O.C.N	vi.⊑.			June	7, 201			
-47		30. Name and address of person			miner one	W Ball	imore	Street	Raltim	ore, MD 2	1223				
		Russell Alexander M		istrar's Signa		vv. Dall		Jueel,	Daitiil		. 1229				
Regis	state strar		2012 2		9. Bark	21									

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012  $A^{M}$ June 7:40 Margaret T. Bowman Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 217-44-5318 1 □ M 2 🔀 F Yrs 1925 June 25, Pennsylvania Usual Residence of Decedent 86 10c. City, Town or Location be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f 1 X Yes 2 ☐ No FLPinnelas St. Petersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 items 23a oner must be Funeral 6897 17th Lane North 33702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. "natural", or iter Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ၉ Herbert Awckland Mary Cronin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Herbert Bowman / Son 7140 Brooks Rd. Highland, MD 20777 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/7/2012 Woodbine, Maryland Signature of Funeral Service Livense Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 XVIII 28a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMPLICATIONS OF DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine If any, leading to immedicause. Enter Underlying Cause (Disease or injury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be lirector, page 2 s autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🔀 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of thours after death.

uneral Director: After thely filled in by the funera 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 29d. Date signed (Month, Day, Year)

the Funeral Directory filled in by within 24 ho
To the Fune
completely f 29b. Signature and title of certifie D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MO 21044 CEDAR LANE DANIELLE .. DOBERMAN, MD 6336 gistrar's Signature State arkel Registrar DHMH 17 Rev 06-2011

JUNE 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 12.25 PM BROWN ROXANNE JUNE 05 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MEDSTAR HARBOR HUSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Min. Hours 217 90 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipartment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exeminer must be considered. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 USA Jack Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 Z No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nome Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Brown SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) arlyn Anderson - daughter Audrey Ave. Balto mo 21225 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Acensee 22. Name and Address of Facility Gary P. March 914 270 Fredhillon Poss Balto. mo 21229 23a. Pm 1. Infor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** > 1 YEAR METASTATIC disease or condition resulting in death) BREACT CANCER /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and an armounts) Due to (or as a consequence of): Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed that initiated events for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☑No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) the funeral 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

of Vital Records, Division 24 hours a

> State Registrar

MAGAMALLIKA JASTI (Month, Day, Year) **JUN 0** 8 2012

29b. Signature and title of certifie

2. Registrar's Signa

and manner stated

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANOVER STREET, BALTIMORE MD-21225

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D70957

29d. Date signed (Month, Day, Year)

JUNE, 06, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Items 23a per dr., g928,06/08/2012dhb

			State Amend Items	23a per dr	•,g928,	06/08/2 Certificate		<b>b</b> eath			Reg. No.	201	2	8180
ш		1. Decedent's Name (First, Middle, Last)  2. Date of Death										ne of Death		
	Physicia Medic		Betty C. Buckler					May	2	5 201	2 10	215 AM		
	Examin		4a. Facility Name (if not institution, g			Location of	Death	0	4c. Co	ounty of Deat	th			
- Rock			Union Memorial H				imor	e If Under 24	/ Uro	O Data of Dist	hl-	I a pi	th-1 (O4	-t Foreign
	Funeral		,		(In yrs. last birtl	Months	Days	Hours	Min.	8. Date of Birt (Month, Da			inplace (Si juntry)	ate or Foreign
	Director		217-40-0828 Usual Residence of Decedent	1 D M 2 X F 6	9	Yrs.				12-30-	1942		MI	)
	and show	5	10a. State 10b. County		10c. City, Town	or Location								de City Limits
	Maryl 8a-f tiffie	Director	MD Baltimo	re	Edgeme	re							1 _	Yes 2X No
	a or 2		10e. Street and Number		"	10f. Zip						n of What Co	ountry?	
	ıs 23 nust	Funeral	2408 Woodridge F			1	219		A / D	- N	USA			
	deat r iten		11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Deced If Yes, spec	lent of His rify Cubar	spanic Origii n, Mexican,	n? (Spec Puerto f	Rican, etc.)	14	. Race - Ame Black, Whit		ın,
36	be filed within 72 hours after death with the Manyland ental Hygiene. 'ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 Yes 2 X If Yes, Give Year or Dates.	10	1 🗆 Yes	2 <b>X</b> No	Specify:			Sp	ecify: Wh	nite	
Maryland 21215-0036	hours natura ical E	lete	15. Decedent's	s Education	16a.	Decedent's Usu (Give kind of wo	al Occupa	ation	- f a ulais		16b. Kind	of Business	/Industry	
215	in 72 e. nan "ı Med	d L	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5+	-)	life. DO NOT use	retired)	uning most (	DI WOIKII	'g				
7	l with ygien her th	Be C	12			<u>Cafeter</u>	ia			(F) 1 A 4' 1 H-			CO So	chools
nd	e filec ntal H ed ot	To B	17. Father's Name (First, Middle, Las	it)						(First, Middle,	Maiden Sui	rname)		
<u>S</u>	uld be I Mer narke natic	-	John R. Young	- Control Original	- Lie	. Mailing Address	(0)	Ora			or City or To	wn Stata 7	in Cade)	
Na	2 sho th and 7 is r		19a. Informant's Name/Relationship	Husband		.08 Wood						land 2		
e,	and Healt tem 2		Julius Buckler  20a. Method of Disposition		20b. Place of	f Disposition (Na	ne of			Jane Date		tion - City o		ate
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Sp			ry, crematory or o	of J∈	sus 5				alk, M		
Balt	permit Depart Import any in		21. Signature of Funeral Service Lid	/ //	M01176	22. Name ar Conne 7110	d Addres	s of Facility Funera ers Po	l Ho	ome of Road D	Dunda unda I	lk, PA	2122	2
			23a. Part 1 Enter the disease, or c	omplications that caused	the death. Do r								Appro	ximate al Between
	Physician/		Immediate dause (rinal disease or condition										and Death	
	Medical Examiner		resulting in death)	Due to (or as a									)	yrs.
	Examine	<u></u>	Sequentially list conditions,	b		ted Bypa	ss G	rafts					6	months
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Canor	on): enous Le	98						10	days
	icate be executed I physician and is the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequence		8-							
0	siciar siciar buris	ledical		d										
3760	ficate g phy as the	Med	UE ECAMALE.				_						<u> </u>	
P.O. Box 68	is that the death certifications by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal deat			СУ			23	ld. Date of d	elivery Day	Year
Bo	deatl he atl	Sici	1 Yes 2 No	4 ☐ Pregnant at g ☐ Unknown	time of death	5 ☐ Other (s	pecify)					Month	Day	
Ö	at the d by 1 detacl		Part II. Other significant condition	is contributing to death by	ut not resulting	in the underlying	cause giv	ven in Part I.		23e. Did	tobacco use	contribute 1	to the caus	e of death?
G,	res th signe d be d	d by								1 🗙	Yes 2	No 3 🗆	Probably	4 🗌 Unknown
ord	requires been sign	Completed								24a. Was		24b. Were a	utopsy find	dings available
ecc	rsician: The law r s certificate has b director, page 2 s	F								auto perf	opsy formed? 2 X No	death?		on of cause of
<u>=</u>	ifficat tor, pa	Be C	.25. Was case referred to medical	I			26. PI	lace of Deat	h (Checi		2 110		00 2	
Vita	ysicia s cer direc	70 B	examiner? 1 ☐ Yes 2 🗶 No	Hospital:	ent 2 ER/O	utpatient 3 🗆 🛭	Oth	er: 4 🗌 Nu	rsing Ho	ome 5 🗆 Res	idence 6 L	Other (Spe	ecify)	
of	ng Ph ter th ineral		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of injur (Month, Day		Time of injury	28c. Injur worl	ζ?	- 1	28d. Describe	how injury of	occurred		
ion	eath. or: Af the fu	ij:	2 Accident Investigation of Could n	ation of he		М		Yes 2	No				10-4-	A formation of
Division of Vital Records,	il or Att after d Direct d in by	Certificate;	4 Homicide determin			arm, street, facto	ry, office			28f. Location City or To	(Street and I wn, State)	Number or H	iurai Houte	Number,
7	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical		Physician: To the best of examiner: On the basis of ex										and manner stated.
	To the within To the somple	Σ	29b. Signature and title of certifier	12.30 Fractioner. To the	200. Of thy Kild	29	c. Licens	e number			29d. Date	signed (Mor	ith, Day, Ye	ear)
9			1		MD	(Tuno Brint)	166	176	549	88	M	as s	15,	2012
	8		30. Name and address of person w	no completed cause of de	201 E	ast Us	ive	ST	7	ackvia	FE	Salti	sto C	e, MD
	Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as states as a superior of the cause o													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month Physician/ BEEMAN JR. JUNE 2012 CHRISTOPHER Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner N/A BALTIMORE HARBOR HOSPITAL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 220-64-4262 Director 1 XM 2 - F 52 Jan. 25,1960 Maryland or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No Maryland Brooklyn Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Numbe an "natural", or items 23a o Medical Examiner must be Funeral 21225 United States 5311 Wasena Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc 0. 1 Never Married 2 X Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates Specific 3 
Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Security Guard Security 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be filed 2 JoAnn M. Winker Christopher C. Beeman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5311 Wasena Avenue, Brooklyn, Maryland 21225 of Health a item 27 i Dolores Beeman / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of Important: If it any injury or o once. 1 
Burial 2 
Cremation 3 
Removal from State Metro Crematory Inc. 06/06/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc Taylor Signature of Funeral Service Licensee Alyson K 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ATMEROSCLEROTIC CARDIOVASCULAR disease or condition resulting in death) Medical **Examiner** DIARETE Sequentially list conditions. rt any, leading to immediate cause. Enter Underlying Cause (Disease or injury pue to for as a consequence of, the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ast IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death 2 🗌 No 1 Yes 2 9 Unknown g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 🗖 Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an COPD autopsy page 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely f (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) MEDICAL DOCTOR 70358 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H4280R HOSPITAC

Registrar
DHMH 17 Rev 06-2011

KENNETH MWATUA

31. Date filed (Month, Day, Year) **JUN 0 8 2012** 

3001

32, Registrar's Signature

SOUTH HANDJER STREET BALTIMORIE, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clarence Russell Bryan, 2012 8:17 A M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19310 Club House Road #413 Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 485-10-8163 Country, Iowa Months Hours **Director** 89 Apr Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19310 Club House Road #413 20886 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 If Yes, Give Year or Dates. 1941–80 1 ☐ Yes 2 K No Specify. Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Naval Officer U.S. Navy Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence R. Bryan, Alyce Marie Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidra Van Norden / Daughter 13728 Wanegarden Dr. Germantown, MD 20874 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1  $\square$  Burial 2  $\boxtimes$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/9/2012 Woodbine, Maryland Signature of Funetal Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Congestive Heart Failure days Medical Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease years attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b lirector, page 2 sl autopsy performed? death? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical director Be 26. Place of Death (Check only one) 1 Yes 2 XNo Other: မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 K Residence 6 Other (Specify) this After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending in 24 hours area in the Funeral Director. Afternated filled in by the funeral funeral filled in by the funeral funeral filled in by the funeral fi 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

within 2 To the F

State Registrar 30. Name and address of person wh

Suhair Abulfarag,

604 S. Frederick Ave. Gaithersburg, MD 20877 31. Date filed (Month, Day, Year)

completed ca

M.D.

DHMH 17 Rev 7/2009

of death (Item 23a) (Type, Print)

D31391

29d. Date signed (Month. Day. Year)

June 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month June David R. Burns 11:56 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 9315 Georgia Belle Drive Paltimore Perry Hall 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min 1 X M 2 🗆 169-62-6115 44 0977371967 Pennsylvania Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Perry Hall 1 😾 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9315 Georgia Belle Dr. 21128 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry should be filed within 72 and of Health and Mental Hygiene.
If I fem 27 is marked other than "n, or other traumatic event (Specify only highest grade completed) Engineering Elementary/Seconday (0-12) College (1-4 or 5+) Consultants Consultant Engineer Be . Page 1 and 2 should be filed tment of Health and Mental Hy tant; If item 27 is marked otl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James C. Burns Lorraine E. DiGiulio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey M. Burns / Wife 9315 Georgia Belle Dr. Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date jo <u>=</u> 10 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Anthony's Cemetery 06/11/2012 Windber, Pennsylvania permit. Page Department of Important: If any Injury or 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licer 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ 6 hoblastoma disease or condition years Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iii jury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Day Pregnant at time of death Year signed by the a be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after dea... ral Director: Aftr 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 29d. Date signed (Month, Day, Year) D37018 2012 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print)

State

Registrar

0

JUN 0 8 2012

31. Date filed (Month, Day, Year)

tecca

Johns

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Mary	•	tificate of D			eg. No. 2	112	18184	
	Physicia	n/	Decedent's Name (First, Middle, La	Bernadette	Nora Caffre	⊋у		2. Date of Death	h	Year	3. Time of Death 3:07 A M	
7	Medic Examin		la. Facility Name (if not institution, gir Gilchrist Cente	e street and number) for Hospice Ca	re		City, Town, or Location of Death  Towson			4c. County of Death Baltimore		
R	Funeral Director	5	101-22-7444	Sex 7. Age (In 1 ☐ M 2 🏝 F	yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 24,	Year)	9. Birthp Count New	olace (State or Foreign try) York	
	aryland a-f show fied at	0 1	Usual Residence of Decedent  10a. State  10b. County  N/A	100	c. City, Town or Loc	cation	Baltimore			1	0d. Inside City Limits 1 X Yes 2 □ No	
	vith the Ma 23a or 28a ist be notif	eral Dire	10e. Street and Number	attery Avenue		10f. Zip Code	21230	1	10g. Citizen of USA		try?	
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if them 27 is marked other than "natural", or items 28a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🗷 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, e		
21215-0036	thin 72 hour sne. than "natu he Medical	Somplet	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		life DO NOT use retired)		luring most of work	ring most of working		e & Mo		
land 2	be filed wii ental Hygie rked other ic event, tt	l on t	17. Father's Name (First, Middle, Las				18. Mother's Nam		Maiden Surnam	re)		
, Maryland	id 2 should salth and M n 27 is mai er traumat		19a. Informant's Name/Relationship Robert Caffrey	(son)	10	5 East Gitt	and Number or Run	al Route Number, Baltimore,	Maryland	2125	30	
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State cify)		natory or other plac <b>Cemetery</b>	<sup>(e)</sup> 6/8		•	Park,	Maryland	
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Inc.		er 22 100175 -	2. Name and Addre 130 East Fo	ss of Facility McC rt Avenue,	ully-rolyr Baltimore,	nak Func Marylan	nd 21	230	
68760 %	rath certificate be executed  x x x attending physician and ifor use as the burial-transit and income.	ledical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	insequence of):	Fibr	_				Interval Between nset and Death	
Box	aw requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transi	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су			ate of deliv	very Day Year	
s, P.O.	requires that the des been signed by the s should be detached	d by Ph	Part II. Other significant condition	s contributing to death but r	not resulting in the	underlying cause gi	ven in Part I.	23e. Did to			the cause of death?	
Records,	he law requ te has beer age 2 shou	omplete						24a. Was a autop perfor	rmed?	Were auto prior to co death? 1  Yes	opsy findings available ompletion of cause of 2 No	
ital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Total	lace of Death (Chec		AT 0	har (Cassif	whospice	
n of V	Attending Physician: The streath.  ector: After this certificate by the funeral director, pag	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day, Y	2 ER/Outpatie 28b. Time of injury	of 28c. Inju wor	ry at	28d. Describe h			))·003/104	
Division of Vital	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury building, etc. (\$	Specify)			City or Tow	n, State)		al Route Number,	
_	Hospit 24 hour Funers etely fills	Medical	(Chook (2 Modical Ev	Physician: To the best of my aminer: On the basis of exar lurse Practitioner: To the b	nination and/or inve	stigation, in my opin	ion, death occurred	at the time. date a	nd place, and d	lue to the ca	ause(s) and manner stated.	
	To the within To the complete	2	29b. Signature and title of certifier	~^	,	29c. Licens			29d. Date sign	ed (Month,	, Day, Year)	
	5		30. Name and address of person w	CHANUES	$\langle \mathcal{N} \rangle$	Print)	N.Cu	mls s	TO	~30.^	2012 VMD	
	Sta	ite	31. Date (100 0 8 2012	32. Register's	Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:55 P M JUNE rra 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Min. Hours 1 M 2 □ F Director 65 MARYIAND ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director BALTIMORE MD 1 Yes 2 \ No 10e. Street and Number 10g. Citizen of What Country Funeral BALLOU 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after de and Mental Hygiene.
is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 Yes
If Yes, Give Baltimore, Maryland 21215-0036 2 No 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) GUARD Elementary/Secondary (0-12) College (1-4 or 5+) 10 MAINTANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 CAMPBELL LEONARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 🗸 ate, Zip Code) 💫 / 🎗 🎉 1 and 2 s of Health item 27 i JOHNSON SISTER PARK 4507 Important: If iten any injury 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY INC 08/2012 BALTIMORE, MARYIAND 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service DERRICK PARK H6ts. that caused the death. Do not enter the mode of dying, such on each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause An roximate Interval Between Onset and Death Immediate Cause (Final Physician/ auces disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to jor as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes မ 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ture and title of cert 1100 00071187 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PWWP Shaheen, 670 (M. Chailes St. \* 4105, Balthwell, MI) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	- State amend 2 per d	State of Maryland / Dep r.,g928,006/08/2012 Cei	artment of Health and 2dhb rtificate of Death	Reg. No. 20	2   8   8 6
	Physicia	n/	1, <del>Dos</del> edent's Name (First, Middle, Last)	Charehors		2. Date of Death 05/19/201	2 3. Time of Death 9:40A M
	Medic Examin		4a. Facility Name (if not institution, give st	reet and number)	4b. City, Town, or Location of Dear	th 4c. County of	Death
	Funeral Director		5. Social Security Number 6. Sex	7 Age (In yrs. last birthday) M 2 🗆 F Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		J. Birthplace (State or Foreign Country)
	3	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation	3-20-1934	10d. Inside City Limits
	with the Maryland  23a or 28a-f sho  ust be notified at	Funeral Director	10e. Street and Number	Balti	10f. Zip Code	10g. Citizen of Wh	1 ☐ es 2 ☐ No at Country?
	death with ritems 23a ner must b	unera	308 Reaux		3/3/2 Was Decedent of Hispanic Origin? (S	Specify Yes or No- 14. Race -	American Indian,
5-0036	ge I and 2 should be filed within 72 hours after death with the Maryland to fleath and Mental Hygiene. If of Health and Mental Hygiene. or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married Married 3 Widowed 4 Divorced	1 Vec 2 No	If Yes, specify Cuban, Mexican, Puèr 1 ☐ Yes 2 No Specify:	rto Rican, etc.) Black, Specify:	White, etc.  Black
215-0	e. e. Aan "natu Medical	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16b. Kind of Busin	ness/Industry
	nled within al Hygiene. I other thar vent, the N	Be	17. Father's Name (First, Middle, Last)	Mar	nterance who	ame (First, Middle, Maiden Surname)	·*/
Maryland	nd Menta nd Menta s marked smartic e	2	Annias Ck 19a. Informant's Name/Relationship (Typ	e, Print Jahan 19b. Mail	ing Address (Street and Number or R	tural Route Number, City or Town, State	re, Zip Code)
	and 2 shu Health ar tem 27 is other trau		Mariow Ch 20a. Method of Disposition	anhers 50 20b. Place of Disp		pate 20c. Location - C	10 2/2/2 ity or Town, State
Baltimore,	<b>4</b> 5 6 9		Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Carris	matory or other place)  There december 5	129/2012/0WIN	95 Mills, MD
Bal	permit. F Departm Importal any injui		21. Signature of Funeral Service Deense	10/553	4965 York.	ID. Balto M	121212
~ F	hysician/		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final disease or condition		ter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence of):	war		Mkraun
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
_	cate be executed physician and sthe burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):			
98760	ertificate be ding physicia se as the bu	/Medi	IF FEMALE:	3c. If yes, outcome of pregnancy		23d. Date	of delivery
. Box 687	nat the death certific ed by the attending I detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	Mont	
s, P.O.	The law requires that the ate has been signed by the page 2 should be detach	by	Part II. Other significant conditions col	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
Division of Vital Records,	The law requate has beer page 2 shou	Completed				autopsy pri performed? de	ere autopsy findings available or to completion of cause of ath?
ital R	sician: The law r certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death (Ch		
n of V	Attending Physician: r death. ector: After this certific by the funeral director,	ate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ ER/Outpatie  28a. Date of injury (Month, Day, Year)  28b. Time of injury		28d. Describe how injury occurred	
ivisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifica completely filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f. Location (Street and Number City or Town, State)	or Rural Route Number,
	Hospital or 24 hours afte Funeral Dire letely filled in	Medical	(Check 2 Medical Examin	cian: To the best of my knowledge, death er: On the basis of examination and/or inve Practitioner: To the best of my knowledge	estigation, in my opinion, death occurre	d at the time, date and place, and due t	o the cause(s) and manner stated.
	To the   within 2 To the   comple	2	29b. Signature and title of certifier	Tractitioner. To the best of my wearing	29c. License number	29d. Date signed (	Month, Day, Year)
	6)		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print)		12012
	/	te	31. Date filed (Month, Day, Year)	700 west 401	or St Scit My	2(2(1)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Delphine Irene Davis 11:30 P M June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Prince George's Hospital Cheverly Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 578-72-9176 Director 1 🗆 M 2 🗶 F 59 Washington, DC Sept 3 1952 Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 ¥ Yes 2 □ No DC: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 6817 Forest Terrace USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 N Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Personal Trainer 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Perry Lailah Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6817 Forest Terrace, Hyattsville, MD 20785 Tamara I. Guest/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 06/11/2012 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 21. Signarure of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metus uver Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner - admicarcipona estina tumos Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown nombe cytovenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 DNo 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred s after dea. Pirector: After 1 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year, May 31, 2012

DHMH 17 Rev 06-2011

Registrar

3001

HOSPITAL

CHEVERLY

20185

Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ivialyia	•	rtificate of L			Reg. No. 20	12	18188	
	Physicia	n/	1. Decedent's Name (First, Middle, I	Betty L. Da	avis			2. Date of Dea Month June		Year	3. Time of Death 8:18 AM	
	Medic Examin	al .	4a. Facility Name (if not institution, g			4b. City, Town, or	Location of Death	June -	4c. Count	of Death	0.10 A	
Ì	<b>E</b> Admin		Shady Grove Adve				kville			gomery		
	Funeral Director		5. Social Security Number 238-74-0082	. Sex 7. Age (In yrs. 1 ☐ M 2 🛣 F 66	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	, Year)	Countr	ace (State or Foreign y) Carolina	
-			Usual Residence of Decedent  10a, State  10b. County	100.0	ity, Town or Lo	ecation		march 2			d. Inside City Limits	
	arylan ka-f sh ified a	ecto	Maryland Montgo		•	hersburg					1 🏝 Yes 2 □ No	
	a or 28 be not	Funeral Director	10e. Street and Number	Count #11/		10f. Zip Code 2087	78		10g. Citizen of			
	ath with	uner	906 Beacon Squa	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		United States  14. Race - American Indian,		
920	s after des ral", or ite Examiner	ج	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces?		If Yes, specify Cuba 1 Yes 2 🛚 No	n, Mexican, Puerto	Rican, etc.)	i	Black, White, etc.  Specify: Black		
2-0	2 hour "natu	Completed	15. Decedent (Specify only highest		(Give	dent's Usual Occup kind of work done of OO NOT use retired)	ation during most of work	ing	16b. Kind of E		ustry ication	
7121	vithin 7 liene. Ir than the Ma		Elementary/Secondary (0-12)	College (1-4 or 5+)		inistrate	or			iation		
and 2	be filed v ental Hyg rked othe iic event,	To Be	17. Father's Name (First, Middle, La William Roland			-	18. Mother's Nam Emmabel		Maiden Surnan	ne)		
Mary	d 2 should alth and N 27 is ma r traumai		19a. Informant's Name/Relationship Keith R. Harley/		19b. Maili 202 M	ing Address (Street ajor King	and Number or Rur Lane, Ft	al Route Numbe . Washir	r, City or Town, ngton, M	State, Zip Co laryla:	nd 20744	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	3 🗌 Removal from State 🛮 Mo	cemetery, cre	osition (Name of matory or other place TY Tium, Inc		Date 13, 12	20c. Location	,		
Balti	permit. Departm Importa any inju	Ī	21. Signature of Funeral S ace Lic	censee MOO1	98 R	2. Name and Addre obert A. 1 00 West Mo	ss of Facility Pumphrey I ntgomery	Funeral Ave., Ro	Home/Rockville	ckvill , Mary	e, Inc. vland 20850	
П			23a. Part 1. Enter the disease, or o shock, or heart failure. List on	ly one cause on each line.	ath. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between	
	Physician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. houl a  Due to (or as a conse		neck co	mor			1	onset and Death	
	Examiner	L	Sequentially list conditions,	b. ————————————————————————————————————						_		
	ed sit	mine	if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):							
_	icate be executed physician and is the burial-transit	edical Examiner	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):							
3760				d	-				_			
Box 68	hat the death certificed by the attending detached for use and	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су		23d. Date of delivery Month Day Year			
s, P.O.	or Attending Physician: The law requires that the lifter death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detach.	ğ	Part II. Other significant condition	ns contributing to death but not	resulting in the	underlying cause g	ven in Part I.				e cause of death?	
Division of Vital Records,	law requires th has been signe ge 2 should be o	Completed						24a. Was auto		. Were autop prior to cor death?	osy findings available mpletion of cause of	
= Re	ician: The la certificate ha rector, page		25. Was case referred to medical			26. F	lace of Death (Che	1 🗆 Yes	2 No	1 Tes	2 No	
Vita	nysician: nis certific I director,	To Be	examiner? _1	Hospital: 1  ☐ Inpatient 2			ner: 4  Nursing H	ome 5 Resi			)	
n of	ding Ph h. After th funeral	ate:	27. Manner of Death  1 Matural 5 Pending		28b. Time of injury	wor		28d. Describe	how injury occu	rred		
ivisio	I or Attend after death Director: A d in by the f	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	not be		treet, factory, office		28f. Location ( City or Tou	Street and Num wn, State)	ber or Rural	Route Number,	
	Hospita 24 hours Funeral tely filled	Medical	(Check 2 Medical F	Physician: To the best of my know xaminer: On the basis of examina Nurse Practitioner: To the best	tion and/or inve	estigation. In my opin	ion, death occurred	at the time, date:	and place, and c	due to the cal	use(s) and manner stated.	
	To the within 2 To the comple	2	29b. Signature and title of certifier			00-11			odd Data sian	and Adamsta I	Day Voorl	
	15 Br		30. Name and address of person	who completed cause of death (II	tem 23a) (Type,	Print)	7)0		June	Mari	01)— and 2083)—	
- 12-	U		Chitra Kajag	opal MD 181	hature .	re Phillip	n Unve, #	327, 6	iney,	Loan 10	re roof	
	Sta Regist		JUN 0 8 2012	32. Registrar's Si	arke							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edmond Dabney State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Medical Examiner 0602 hrs June 3, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. laşt birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country) Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e, Street and Number 10f Zip Code 10g. Citizen of What Country 21215 US Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specity Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Never Married 2 Married Yes Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry eted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surna Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sister alaa3 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 rematory Donation 5 Other Specify Metro re of Funeral/Service 2004 O. March Fly 270 Fredhilton Pass Balto Ever the dise 🔩 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed s certificate has been s rector, page 2 should t 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 Yes Certification: To 2 No 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Jun 3, 2012 Subject shot 0315 hrs Pending 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director: filled in by the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 4600 Block of Pimlico Road, Baltimore, MD determined (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 4, 2012 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2012 Doris Irene Dixon 9:45 PM June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Rinth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 212-24-5780 84 **Director** 1 🗆 M 2 🏝 F Yrs 3-2-1928 MD Usual Residence of Decedent 28a-f show the Maryland notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 2852 Patapsco Rd. 21048 USA death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give "natural", or item ledical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2K No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ George C. Knight Myrtle Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Taylor-daughter 21117 233 Embleton Rd., Owings Mills, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cem. 6-11-12 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Ligensee 22. Name and Address of FacilityFletcher Funeral Home When 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ₺ 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has performed? Yes 2 No death? Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3200 Name and address of person who completed cause of death (Item 23a) (Type, Print) 114 Business Center De

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)
JUN 0 8 2012

Reisterstan, MD 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 06 Carolyn Adams Dunn 2012 8:40 AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9505 Hale Street Silver Spring Montgomery 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 04/ Pay 1940 Days 1 🗆 M 2 🗀 F Director 523-50-1931 New Jersey 72 Yrs Usual Residence of Decedent 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery 1 Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Department of Health and Mental Hygiene. Important: If item 27 is marked other than "- any injury or other traume\*\*-9505 Hale Street 20910 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 Yes 2X No Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Librarian Public Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Ross Adams Lois Hickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Dunn / Son 9505 Hale Street, Silver Spring, MD 20910 20a. Method of Disposition
1 
Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) Chesapeake Crematory 6/8/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Joule Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury Directo for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be c Records, Certificate: To Be Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tes 2 No th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29d. Date signed (Month, Day, Year) D27521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 ANNAPOLIS ROLAI LANHAM, MD 20700 MD Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year dwards JUNF 11:40 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL TWIAZ AGMES BALTIMORE 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Min Director 212-82-5349 Usual Residence of Deced 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No M D Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Magellan Elementary/Seconday (0-12) College (1-4 or 5+) Ca tiali cialist Be 17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Surname) ၉ (ma 19a. Informant's Name/Relationship (Type, Print) (Husbard) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) raio lwood 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12012 22. Name and Address Faculty 21. Signat Funeral Service Licensee Home, ral (to., 23a. Part 1/Enter the disease or complications that caused shock, or heart failure. List only one cause on each line r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final STAGE BREALT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🛣 No Other: Certificate; To 1 XInpatient 2 PR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No injury Accident
Suicide Investigation 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier DAN WIKAN 29d. Date signed (Month, Day, Year) , M.D D72450 June 6, 2012 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DURGA DHOS ADHIKARI, 900 Laton Avenue, Baltimore, MD-21229

DHMH 17 Rev 7/2009

Registrar

JUN 0 8 2012

W

FUNIT

FUNARDS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0. Entin 2012 Harry 7:55 AM Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospita Regional Laure George rince 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 231-37-2564 56 Yrs. 1 🕱M 2 🗆 F Jun 27,1955 Sierra Leone or 28a-f show notified at show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Largo 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 20774 123 Harry S. Truman Drive #14 United States items ; within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, f Health and Mental Hygiene.

Item 27 is marked other than "natural", or ite
other traumatic event, the Medical Examiner Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Officer Government 12 th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Entin Harriet Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry S. Truman Dr #14, Largo, MD 20774 Rita M. Entin / Wife 1123 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State George Washington 6/16/2012 1 X Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 Donation 5 Other (Specify) permit. 21. Signatur Fuperal Service Licen 22. Name and Address of Facility JB Jenkins Funeral Home. 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic **Physician** Shock disease or condition Medical resulting in death) Due to ( as a consequence of)
Aspiration Examiner eumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir burial-transi and Due to (or as a consequence of): nding physiciar Physician/Medical The law requires that the death certificate be Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jo signed by the a ld be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Infection Iract Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Respiratory Chronic 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has autopsy death? Mass Liver certificate 2 X No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 3, 2012

DHMH 17 Rev 06-2011

State Registrar Regional

Hospita

<u>aurel</u>

32. Registrar's Signature

7300

Dusen Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Ali

31. Date filed (Month, Day, Year)

Godi

Nega

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #5 Fer FH G928 6/25/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Howard Nathan Eskildson 2012 June 6, 8:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery Montgomery Hospice Casey House 5. Social Security 2598 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 213-56-5 62 **Director** 1 🖾 M 2 🗆 F Feb. 21, 1950 Tennessee 28e-f show I and 2 should be filed within 72 nours ..... of Health end Mental Hyglene. I Item 27 is marked other then "neturel", or items 23e or 28e-f shov I Item 27 is marked other then "neturel", or items 23e or 28e-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Rockville Montgomery 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 711 Mapleton Road United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 K Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

Laboratory Animal Supervisor (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Biotech Research æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hugo Nathaniel Eskildson Anita Coyn Knemeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20850 711 Mapleton Road, Rockville, Maryland Joan R. Garg/Partner 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a, Method of Disposition 20c. Location - City or Town, State Date Page 1 June 10, 2012 1 Burial 2 S Cremation 3 Removal from State Department of Importent: If eny Injury or one Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc M00198 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Esophageal Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physicien and for use as the burlal-transit Cause (Disease of mjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physicien: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death IF FEMALE: 23b. Was dec edent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 Yes 2 9 Unknown 2 No is after death.

I Director: After this certificate hes been signed by the ead in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 区 Other (Specify) Hospice 1 🗌 Yes 2 🖾 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funerel Director: Af completely filled In by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Decrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Road, Rockville, Maryland 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

JUN 0 8 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1130 P Month Physician/ HENRY EHRLICH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE PIKESVILLE ENVOY OF PIKESVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours 0372871930 Country) 1 🛛 M 2 □ F MD 214-26-9806 82 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 X No MD BALTIMORE PIKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 USA 16 FARMHOUSE COURT death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced WHITE Year or Dates other traumatic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING SALES Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ ARGA EHRLICH RAE 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 FARMHOUSE COURT, PIKESVILLE, MD 21208 SAUNDRA EHRLICH/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON CEMETERY—
CHIZIK AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State 06/06/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service 21. Signal 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EMA WITH METASTATIC DISSASE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗗 No ျ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation ☐ Accident after death | Director: / d in by the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours af the Funeral Di mpleted filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet only one) 29b. Signature and title of certifie B88852 VUNE 5 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

KATHUSEN C. SIAMONS

8 0 AUL

31. Date filed (Month, Day, Year)

2835 Smith AUSMUE BONSTHOLL, MARY /Dry 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mroz Foehrkolb June 6, 2012 3:13  $P^{M}$ Audrev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard Ivy Manor Normandy If Under 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Director 215-28-1098 Usual Residence of Deced 1 □ M 2 **X** F 81 June 11, 1930 Maryland ms 23a or 28a-f show must be notified at 10d. Inside City Limits I0a. State 10b County 10c. City, Town or Location Director Baltimore Maryland Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Oberle Avenue 21221 U.S.A. or items lygiene. other than "natural", o. ... \*\* the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Z1215-0036

Zeratinent of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other them. þ 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 √ Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eva Gulczynski Joseph Mroz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Foehrkolb, Jr. (Son) 30 Congressional Court, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) St. Stanislaus Cemetery 06/11/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si natur ul la la Servi Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Essex, Maryland 21221 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ement19 Immediate Cause (Final Onset and Death Physician/ disse or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to for as a considuence of cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at id be detached for 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy performed? Yes 2 X No certificate has 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? **Assistea** Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \textbf{X}\) Other (Specify) မ 1 🗌 Yes 2 **X**lo 1 Inpatient 2 ER/Outpatient 3 DOA Living After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A ☐ Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mace Avenue Baltimore Name and address of person who complete MID

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 06766/2012 5:22P JR FRENCH **GEORGE** HARVEY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Blakehurst If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours (Month, Day, Year) 89 216-16-5608 **XX**M 2 □ F Director Yrs 07/07/1922 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b Counts 10c. City, Town or Location within 72 hours after death with the Maryland at Director or than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified 1 ☐ Yes 2 👿 No Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21204 USA 1055 West Joppa Road 14. Race - American Indian. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?
1 X Yes 2 No WWII Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 Specify White 1 ☐ Yes 2 X No Specify If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Construction President Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked ot jury or other traumatic even Lillie Mae Mitzel George Harvey French Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 707 Hidden Bluff Circle Catonsville, Maryland 21228 Son George Harvey French III permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State GreenMount Crematory 06/08/2012 |Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of FMPtchell-Wiedefeld Funeral Home Inc ignature of Funeral Stryice Lic 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between Onset and Death Immediate Cause (Final as ila ma Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reaching to immediate cause. Enter Underlying Examiner Disk to for as a consequence of law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year 5 Other (specify) Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has the Hospital or Attending Physician: The 2 No 1 ☐ Yes 2 ☐ No certificate Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မြ After this of funeral directions 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending virthin 24 hours after uea....

To the Funeral Director: Afte 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certific Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature\_ar 2 D0071787 Name and address of person who completed cause of death (Item 23a) (Type, Print) \*4105, Baltimere, MD 21204 haheen, 01 JUN U & 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3 Day 2012 Year JUNE ELLSWORTH W. FORD 4:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S BRADFORD OAKS CENTER CLINTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) Director 212-54-6166 1 🕅 M 2 🗆 F 62 NOV 27 1949 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits MD PRINCE GEORGE'S UPPER MARLBORO 1 Tyres 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be Funeral 23a 9922 GAY DRIVE 20772 USA ral", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES L. FORD GWENDOLYN MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA S. FORD/WIFE 9922 GAY DRIVE UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important; If ite any injury or ot 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 6/9/2012 CLINTON, MARYLAND . Signature of Funeral Service Licensee 22. Name and Address of Facility  $J.B.\ JENKINS\ FUNERAL\ HOME, INC.$ Naphne 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2x No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4x Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D35206 JUNE 5, 2012

State Registrar DHMH 17 Rev 06-2011

ORIGINAL

LIVINGSTON ROAD # 101 FORT WASHINGTON, MARYLAND

20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701

egistrar's Signature

32.

MD

<u>JUN 0</u> 8 2012

WILLIAM TANNER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-State of Maryland Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical or Location of Death **Examiner** 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth In yrs. last birthday) **Funeral** (Month, Day, Year) Country) 561-74-7287 **Director** 1 M 2 X F 60 Nov. 16,1951 Illinois Usual Residence of D 10c. City, Town or Location Las Vegas or 28a-f show 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a to 0a. State **Nevada** traumatic event, the Medical Examiner must be notified at Director Çlark 1 ☐ Yes 2X No lver Spring 10f. Zip Code 89134 10g. Citizen of What Country? 10e. Street and Number 3028 Craddle Mountain Dr. Funeral 15013 Haslemere Court 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify: White 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical / Private Dosimetrist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Petri Lucille Scott Marion Edward Peggy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer L. Leonard / Daughter 1340 Alderton Lane, Silver Spring, MD or other t of Heal 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) permit. Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important III any injury or 4 X Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 06/05/2012 Bethesda, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Fun al Servi 23a. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mod of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events the burial-trar The law requires that the death certificate be execu resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 tho ☐ Live Birth 2 ☐ Fetal deat
☐ Pregnant at time of death
☐ Unknown page 2 should be detached for Day Month Year the a 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause oven in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Ves 2 certificate has 1 Yes 2 No No To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 Yes ER/Outpatient 3 DCA မ Inpatient 2 After this 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending s after death. 2 No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ause of death (Item 23a) (Type, Print) PRINCE PAIL A DR

State

31. Date filed (Month, Day, Year)

JUN 08

Stuart Edward	Fitzgerald
---------------	------------

2012	182	200
------	-----	-----

tuart Euwaru i	Ī	11- For State Certificate of Department of The Certificate			g. No.	2 1820
Physici Medical Exam	an/	1. Decedent's Name (First, Middle, Last) Stuart E. Fitzgerald, Jr.		2. Date of Death Month June 1, 20	Day Year	3. Time of Death 1349 hrs
			ity, Town, or Location of Deat altimore	th	4c. County of Death	
Funeral Director		216-84-7221 1XM 2F 44 Yrs.	Under 1 Year   If Under 24Hi Ionths Days Hours Mi		1968 Soul	
faryland 28a-f show any 1at once.	or	Usual Residence of Decedent  10a. State	Baltimo			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 2917 HollinsFerry Road	f. Zip Code 21230	10	g. Citizen of What Coun U	try? SA
p, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Montal Hygien feath and Montal Hygien from 27 is marked other than "natural", or items 23a or 23a-f she traumatic event, the Medical Examiner must be notified at once	by Funeral	Armed Forces? If Yes, s    Married   Armed Forces   If Yes, s   Midowed   Armed Forces   If Yes, s   Midowed   Armed Forces   If Yes   No     Midowed   Armed Forces   Midowed   Armed Forces     Midowed   Armed Forces   Armed Forces     Midowed   Armed Forces   Armed Forces     Midowed   Ar	cedent of Hispanic Origin? ( Specify Cuban, Mexican, Puert 2 No specify:	to Rican, etc.)	White, etc. Specify:	White
36 un 72 hours s. than "natu	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	sual Occupation (Give kind of f working life. DO NOT use re Carpenter		16b. Kind of Business/Ir	
21215-0036 uld be filed within 72 houn Mental Hygiene. marked other than "nath	Be Com	17. Father's Name (First, Middle, Last) Stuart E. Fitzgerald, Sr.		ne (First, Middle, M rlotte Ar		
MD 21. d 2 should blth and Mer. n 27 is mar.	To	Charlotte A. Ochs/ Mother 2917 H	dress (Street and Number or Ollins Ferry	Rd. Balti	imore MD 21	230
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within poptruent of Health and Mental Hygene. Important: If item 27 is marked other II injury or other traumatic event, the Med		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition crematory or other plants are a compared to the compared to th	atory 6	Date /7/2012	20c. Location - City or Thanover Ma	
		victor P. Doua Char	and Address of Facility Les L. Steven E. Fort Ave	BAltimore	e MD 21230	Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		or respiratory arres	st, shock, or heart	Between Onset and Death
	Je.	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):				
ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    C. Due to (or as a consequence of):				
), be execute sician and urrial - trar	dical	d.  UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoreral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (	eath 3 Ectopic pregr	nancy	23d. Date of delivery Month D	ay Year
ires that the de signed by the	by Physic	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		pacco use contribute to to 2 ✓ No 3 Proba	
Records, The law require cate has been sipage 2 should b	Completed			24a. Was al autops perform 1 Yes 2	y prior to co	opsy findings available impletion of cause of
Vital Recaysician: The I	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient 3	26 Place of Death (Check	k only one) sing Home 5 7	Residence 6 Other:	
ion of V tending Phy eath. ior: After thi	tion: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month Day Year)  Jun 1, 2012  1310 hrs			ow injury occurred	
Division of the point of the price of the control o	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Sidewalk	ctory, office building, etc.		treet and Number or Rur ate) r Street, Baltimore, M	
Divisior  To the Hospital or Attend within 24 hours after death. To the Fuoeral Director: completely filled in by the:	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred a which one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	it the time, date and place, an in my opinion, death occurred	nd due to the cause I at the time, date a	nd place, and due to the	cause(s)
F * F 2	Me	29b. Signature and title of certifier  Mu Brown A	29c. License number O.C.M.E.		29d. Date signed (Mon June 2, 2012	th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Ba	altimore Street, Baltim	ore, MD 21223	3	
S Regis	tate trar	31. Date filed (Month, Day, Year)  31. Registrar's Signature	,			

12-04216 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 1820 Louise A. Gilliard State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day June 3, 2012 **Medical Examiner** 1715 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 334 Presstman Street 2nd floor Baltimore 5 Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Director 2-152 1 M Yrs Usual Residence of Deceder J. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No nr 28a-f show traumatic event, the Medical Examiner must be notified at once, hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? man or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 No 1 Yes Yes, Give Year 4 Divorced 1 Yes 2 No specify: ac Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked rather than "natural?", <u>≨</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٥د 20c. Location - City or Town, State 21207 20b. Place of Disposition (Name 1 Burial 2 Cremation 3 Removal from State crematory or other place) Other Specify Cremestor 21. Signature of Juneral Service Jenses Funeral Home, P. A. 33 23a. Part I. Enter the diseas or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medica a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 ✔ Unknown Unknown Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been in the function of the control of 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed<sup>a</sup> Yes 2 V No 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Hospital or Attending Physician: Be Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🗸 Natural Director: d in by the fi 5 Pending 1 Yes 2 No within 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 [ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

OCME

30. Name and address of person who completed cause of death (item 23a)

29b. Signature and title of certi-

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

and manner stated,

Assistant Medical Examiner

32. Registrar's Signature

**ORIGINAL** 

June 4, 2012

2 Wedicel Exeminer:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Urban Guntner 2012 June 5 10:02 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Dec 13, 1922 **Funeral** 9. Birthplace (State or Foreign 216-16-3587 89 Director Mary land 1 XM 2 - F ms 23a or 28a-f show must be notified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Rd., #216 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 X Yes 2 No
If Yes, Give
Year or Dates. WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 □ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Communication Engineer/Sales Radio Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Otto Joseph Guntner Marie Anna Rebhun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 John Guntner-son 12009 Boxer Hill Rd., Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: if it
any injury or o cemetery, crematory or other place)
Moreland Mem'l Park XI Burial 2 Cremation 3 Removal from State 6/8/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ement Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (University of the Cause (Univer Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director; page 2 should be detached it 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Be B 25. Was case referred to medica **Division of Vital** 26. Place of Death (Check only one) 1 Yes 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON NRS an 6701N 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 31 2012 3:00 May Rowena Hunter Medical 4a. Facility Name (if not institution, give street and number) Patuxent River Health and Rehabilitation Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Laurel If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 214-13-5509 63 **Director** 1 🗆 M 2 🗶 F APRIL 25 1949 LIBERIA Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at should be filed within 72 hours after death with the Maryland Director r 28a-f s notified MD MONTGOMERY GAITHERSBURG Yes 2 No 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral 20879 18912 IMPULSE LANE LIBERIA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Specify: BLACK Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) 12TH College (1-4 or 5+) and Mental Hygiene. GOVERNMENT ACCOUNTANT permit. Page 1 and 2 should be filed. Department of Health and Mental H. Important: If item 27 is marked ott any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, LAFAYETTE JACKSON FRANCES BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IMPULSE LANE GAITHERSBURG, MARYLAND 20879 P. HYDARA/DGT. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2012 SILVER SPRING MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. allow 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events DEMENTIA and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No P Month Day Year Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires LEFT CEREBROVASCULAR ACCIDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💢 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital 은 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ģ 4  $\square$  Homicide determined within 24 hours after

To the Funeral Direct

completely filled in b City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M-1 31, 2012 MAYD26721

M DHMH 17 Rev 06-2011

State

Registrar

14333 Laurel Bowie Road, Ste. 208, Laurel, MD 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Sadiq, M.D.,

JUN 0 8 2012

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 12:10 PM Edward Hanson June Craig Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12801 Short Hills Drive Clarksburg Montgomery Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1955 1 X M 2 D F 579-64-5670 56 Maryland **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 6433 Rock Forest Drive, #304 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes
If Yes, Give Baltimore, Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. Is marked other than "natural", 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Programs Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Edward Hanson Catherine Thayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Kristina Price / Daughter 12801 Short Hills Drive, Clarksburg, Maryland 20871 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Montgomery Crematorium, Inc. June 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc ingefette Brand M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final 15 Months Physician/ Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 2 No ed by the a g Unknown g 🗌 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, has been signed 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 🗌 Yes 2 🗌 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Daughter's Hospital Other: 1 ☐ Yes 2 💢 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Residence this 27. Manner of Death 1 🗡 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director After 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Director / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Banne

Paul A. Bannen, M.D.

Seven B. pares

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

MD060335

18111 Prince Philip Drive, Ste. 327, Olney, Maryland 20832

June 6, 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) June 2012 6:27 P M Physician/ Lloyd Vernon Hinton Medical 4c. County of Death 4b. City, Town, or Location of Death la. Facility Name (if not institution, give street and number) Examiner Montgomery Rockville Casey House Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6 Sex Social Security Number Days (Month, Day, Year) Funeral Months 578-34-8248 1 X M 2 | F Director Yrs Washington DC May 3, 1930 82 10d. Inside City Limits 10c. City, Town or Location 1 and 2 should be filed within 72 hours efter death with the Marylend of Heelth and Mental Hyglene.
Itsm 27 is marked other then "neture!", or items 23s or 28e-f show other treumstic event, the Medical Exerciper must be notified at 10b. County 10a. State Director 1 🗆 Yes 2 🔀 No Ashton Montgomery MD 10g. Citizen of What Country? 10f Zip Code 10e Street and Number United States Funeral 20861 900 Ashton Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces X Yes 2 ☐ No Yes, Give 1 Never Married 2 Married 5 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced Year or Dates. 1953-75 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) U.S. Navy Commander 5+ 18. Mother's Name (First, Middle, Maiden Surname) B 17. Father's Name (First, Middle, Last) Bylinsky ၉ Jessie Lloyd Vernon Hinton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ashton, MD 20861 900 Ashton Rd. Ruth H. Hinton / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pege 1
Depertment of
Important: If it
sny injury or o 1 Burial 2 Cremation 3 Removal from State Woodbine, Maryland 6/8/2012 Final Journey Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Kidense 23. Part 1. Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Lung CA Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the attending physicien and the driver transit Physician: The lew requires that the deeth certificate be sxecuted Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ete hes been signed by the attending p pags 2 should be deteched for use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy After this certificate has performed? Yes 2 X N 26. Place of Death (Check only one) To the Hospital or Attending Physician: " within 24 hours effer death. To the Funsrel Director: Affer this certiflor completely filled in by the funerel director, 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 6 D Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No ၉ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: or Attending 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Investigation ☐ Accident ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 7, 2012 D60634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMH 17 Rev 06-2011

State

Registrar

Bindu Joseph
31. Date filed (Month, Day, Year)

8 O NUL

6001 Muncaster Mill Rd.

Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 81000M June 2012 Harry Craig Hinson /Medical County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore Sinai Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F Yrs. 68 July 15, 1943 North Carolina Director 213-40-5206 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1XYes 2 No 28a-f sh Director MD Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or with United States 2434 West Belvedere Avenue 21215 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or iter any injury or other traumatic event, the Medical Examiner aney. Armed Forces.

137 Yes 2 No
If Yes, Give
Year or Dates: 1964-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elevator Technician Elevator Maintenance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ John Grove Rachel Earnhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grove / Brother 6353 Amherst Ave. Columbia. Alan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Final Journey Crematory 6/7/2012 4 □ Donation 5 □ Other (Specify) Woodbine, Maryland 21. Sign the of Funeral Servic Liven 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical Division or Vital Records, P.O. Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 🗌 Yes 2□ No 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe rmed2 2 No certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 은 After this 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🛫 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier

State Registrar

2434 Belvedere Ave. Baltimore, MD 21215 Thomas Byrne 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and I	Mental Hy	giene	
_		State Registrar Certificate of Death	_	Reg. No. 2 ()	12 18208
Physician	,	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Dav	3. Time of Death
Medica	ıl	Clara Louise Hollenbaugh  4a. Facility Name (if not institution, give street and number)  4b. City. Town, or Location of Death	MAY	30 2	012 11-14 A M
Examine	r	and stay, term, or advance of a second		4c. County o	
Funeral		Baltimore Washington Medical Center Glen Burni  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs.	8. Date of Bir		nne Arundel  9. Birthplace (State or Foreign
Director		213-26-2091 1 M 2 🕅 F 81 Yrs. Months Days Hours Min.	(Month, Da	iy, Year)	Country)
D M		Usual Residence of Decedent	01/03/	1931	Maryland
ırylan h-f sh	2	, , , , , , , , , , , , , , , , , , , ,			10d. Inside City Limits 1 ☐ Yes 2X No
or 286	Ulrector	MD Anne Arundel Glen Burnie  10e. Street and Number 10f. Zip Code		10g. Citizen of W	
with ti	Funeral	7954 Castle Hedge Dell 21061	ŀ		U.S.A.
eath (	֓֟֟֟֟֟֟֟֟֝֟֟֟	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (So	ecify Yes or No-		- American Indian,
ther d	ລ	1 Never Married 2A Married 1 Yes 2X No	Rican, etc.)		, White, etc.
ooconiurs a la Exa	red	Year or Dates.		Specify:	White
15- 72 ho n "na fedic	Сотріете	15. Decedent's Education (Specify only highest grade completed)  [Second of work done during most of work life. Do NOT use retired)	king	16b. Kind of Bus	iness/Industry
vithin piene.		Elementary/Secondary (0-12) College (1-4 or 5+) Waitress		Re	estaurant
filled v filled v vent,		17. Father's Name (First, Middle, Last)  18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.	2	Harvey W. Krause Klara		Ihle	·
Mar 2 shot th and 27 is n traum	ı	19a. Informant's Name/Relationship (Type, Print) Husband  Mr. Howard G. Hollenbaugh / 7954 Castle Hedge De			
re, l and l'Healitem 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of	Date Date		e, MD 21061 Dity or Town, State
mo Page lent of		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Cemetery, crematory or other place)  MD Veterans Cemetery 06/0			sville, MD
Balti Permit. F Departm Importa any inju	1	21. Signature of Funeral Service Licensee MO1479 22. Name and Address of Facility 1 2			
D B E E	4	Singleton Funeral	& Crema	tion Serv	vices, PA
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory an	rest,	Approximate Interval Between
Physician/	1	Immediate Cause (Final disease or condition resulting in death)	ACCII	DENT	Onset and Death
Medical Examiner	1	resulting in death)  Due to (or as a consequence of):			
÷	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
50CLA.  Te be executed hysician and he burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events  c			
50666 te be executed te be executed to be burial-transi		resulting in death) Last Due to (or as a consequence of):			
7600 cate by physic s the b		d			
Ox 6876  Ox 6876  authoriticate attending phy  of the sea the		F FEMALE: 23c. If yes, outcome of pregnancy		024 Data	of delivery
Box death or attenned for u		in the past 12 months?  1  Live Birth 2 Li Fetal death 3 Li Ectopic pregnancy  1  Yes 2 No Pregnant at time of death 5  Other (specify)		Mont	of delivery h Day Year
20. Box 6871 hat the death certificated by the attending pleatached for use as the physician/Metached		9 Unknown 9 Unknown			
S, P.C. Signed d be def	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ute to the cause of death?
Records, The law requires are has been sig, page 2 should it			1 🗆 `	Yes 2 X No 3	Probably 4 Unknown
ARA  //ital Reco sician: The law is certificate has be lirector, page 2 s	2		24a, Was autop	osy pri	ere autopsy findings available or to completion of cause of ath?
n: The ficate or, page Co.		25. Was case referred to medical	1 Ves	2 No 1	Yes 2 X No
Vital Vital hysician: his certific	١	examiner?			
of V of V g Phys er this neral d		77. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at		lence 6 Other	
Sion of 'sion of 'death.  Stor: After this y the funeral		2 Accident Investigation M 1 Yes 2 No			
Division of Vital Records, ral or Attending Physician: The law requires is after death.  The librector: After this certificate has been signed in by the funeral director, page 2 should be completed.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		or Rural Route Number,
Division of Vital Records, P.O. Box 6876  Hospital or Attending Physician: The law requires that the death certificat 44 hours after death.  Funeral Director: After this certificate has been signed by the attending phasely filled in by the funeral director, page 2 should be detached for use as the edical Certificate: To Be Completed by Physician/Meredical Certificate:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	nd due to the ca	use(s) and manner	as stated
Div.  To the Hospital of within 24 hours af to the Funeral Discompletely filled it completely filled it.  Medical C		(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place.	t the time, date a	nd place, and due to	the cause(s) and manner stated
To the within 2 To the comple		9b. Signature and title of certifier 29c. License number		29d. Date signed (	
		Harunder Sigh Aroy MD DOOG121	9	MAY	30,2012
- H		10. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HARVINDER SINGH ARORA BWMC HOSPITAL (	GLEWB	URNIF	MD 21061
State		1. Date filed (Month, Day, Year)  JUN 0 8 2012  32. Registrar's Signatus		, , , ,	/
Registrar		JUN 0 0 2012 Central 12. 17			

DHMH 17 Rev 06-2011

Physician/ Medical **Examiner** 

Baltimore, Maryland 21215-0036

Physician/

Medical

Examiner

**Funeral** 

aţ

ms 23a or 28a-fs must be notified

item 27 is marked other than "natural", other traumatic event, the Medical Exa

al Hygiene.

and Mental I

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Director

þ

Completed

Be

Director

The law requires that the death certificate be executed

Box 68760

P.O. I

Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. It

State

	SHOCK, OF HEAR FAILURE. LIST OFFING O	le cause on each line.		interval between			
	Immediate Cause (Final disease or condition	Metastatic Breast Cancer		Onset and Death 3 Years			
	resulting in death)	Due to (or as a consequence of):					
xammer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):					
aucai E	resulting in death) Last	Due to (or as a consequence of):  d					
ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	elivery Day Year				
ed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to				
ompiere			autopsy prior to performed? peath?	utopsy findings available completion of cause of			
96	25. Was case referred to medical examiner?	26. Place of Death (Check only					
0	1 Yes 2 X No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6X Other (Spec	Assisted Living			
licate:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28d. Date of injury (Month, Day, Year)   28b. Time of injury   28c. Injury at work?   28d. Injury at work?   28d. Injury at work?   28d. Injury at work?	28d. Describe how injury occurred				
ll cert	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ıral Route Number,				
3		sician: To the best of my knowledge, death occurred at the time, date and place, and du					

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Frederick P. Smith, M.D. 5454 Wisconsin Avenue #1300, Chevy Chase, Maryland 20815

29c. License numbe

D33293

29d. Date signed (Month, Day, Year) June 6, 2012

DHMH 17 Rev 06-2011

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

<u>JUN 0 8</u> 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-04030 2012 Cynthia Aileen Jakum State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 27, 2012 1910 hrs **Medical Examiner** Cvnthia Aileen Jakum 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford 415 Congress Avenue Apt. 3 Havre de Grace If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreian Months Davs Hours Director Country) Maryland 1 M 2 X F 03/15/1950 218-54-0718 62 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Harford Havre de Grace Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene.

ant. If item 27 is marked other than "natural", or items 23a nr 28a-f shu rather transatic event, the Modital Examiner must be notified at ones. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21078 415 Congress Ave., Fl. 3 Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 2 🔀 No Yes White 1 Yes 2 No specify: 4 X Divorced If Yes, Give Yeer Specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Elderly Care MD 21215-0036 Caretaker 5+ 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beulah Persons 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 Steeplechase Drive, Jarrettsville, MD 21084 Melissa Ann Yarworth / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Beltsville, MD 6/4/2012 Chesapeake Crematory 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service J Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death Complications of Cirrhosis of the liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical AMENDED 23a, pt. II, 27, per me, g928 6-13-12 sm X UNPENDED the attenting physician red for us as the burial Division of Vital Records, P.O. Box 58760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown ğ Chronic Alcohol Use Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 Yes 2 No After this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification 1 X Natural 1 Yes 2 No Pending the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ga 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

State 31. Date filed (Month Day, Year) Registrar 32. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

May 28, 2012

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

12-04178 Thomas Kennedy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

		1- For S Registra	ır		o Marylang	Depart Certif	ment of ficate of I	Health a Death	and Ment	al Hygiene		20	12 18	? 2
Phys Medical Exa	icia		dent's Name (First,		•					2. Date of		0.	3. Time of Death	th
		T f l,	Omas Pa	etric	k Kenned ve street and number)	У	Lab	City Taylor		June 2			0845 hrs	
		Gil	christ Hospice		, and the manually			Columbia	or Location of	Death	ľ	tc. County of D Howard	eath	
Funer Direct		5. Socia	Security Number	6. S	ex 7. Age	(In yrs. last I	birthday)	If Under 1 Y		24Hrs. 8. Date o	f Birth (MI	M/DD/YYYY) 9.	. Birthplace (State or	
	OI		<b>8-34-895</b> 4		M 2 F	68	Yrs.	Months Da	ays Hours	Min.	/16/1	]Fo	country) DC	jto
any .		10a. Sta	te 10b. Co			10c, City, Toy	wn or Location			01/	10/1	744		
<b>*</b>	DCE	⊾ MI	) H	oward									10d. Inside City I	
ne Maryland	o at o	10e. Stre	et and Number Linde			CIai	rksvil]	L.⊖ Of. Zip Code			10a. Ci	tizen of What C	1 Yes 2	X No
ith the		131	.11 <del>Londo</del>	<del>n</del> Chu	rch Road			21029	9			.S.A.	, out injy	
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. red other than "asturan", or items 23s or 28s-f she	Be Completed in First Property	11. Marit	al Status ever Married 2		12. Was Decedent E	ver in U.S.	13. Was D	ecedent of H	lispanic Origin	? ( Specify Yes or uerto Rican, etc.)	No-	14. Race - An	nerican Indian, Black,	,
after de	T T				1 X Yes 2 If Yes, Give Year	No	1 -	s 2 X N		derio Ricari, etc.)		White, etc	2.	
hours a	1 2		edent's Education	(Specify or	or Dates: nly highest grade comp	eleted) 16a	Decedent's	Usual Occupa	ation (Give kin	d of work done	16b	Specify: Kind of Busines	White	
36 in 72 in	Completed	Eleme	ntary/Secondary (0	-12)	College (1-4 or 5-		during most	of working life	e. DO NOT use	e retired)	,	and of Dusines	ss/industry	
15-003 illed withi Hygiene.		17. Fathe	r's Name (First, Mic	ddle, Last)	2	E	<u>Busines</u>	s Owne	er			Automo	tive	
MD 21215-0036  4 2 should be filed within 7 th and Mental Hygiene.  2 7 is marked other than		Jam	es Jose	-ph	Kennedy					lame (First, Middle	, Maiden	Surname)		
D 2. should and Me	٤	1	mant's Name/Relat	ionship (T	ype, Print )	19	9b. Mailing Ad	dress (Stre	Elsie et and Number	Joan or Rural Route N	Umber, C	wd ity or Town, Sta	ate. Zip Code)	_
		Kev 20a. Meth	in Kenned	dy /	Son	- 1	2101 L	inden	Lane	Silver S	princ	a. MD 2	0910	
Baltimore, permit, Pages I ar Department of Hee Important: If ited		1 Bu	ial 2 Crema	ation 3	Removal from State	crema	atory or other p	olace)	anotery,	Date	20c.	Location - City	or Town, State	
altin mit. P partme Portan		4 X Do	nation 5 Other	r Specify: vice Licent		Anato	my Gifts	Regist	ry 06	5/07/201:	2 На	nover,	Maryland	
	_	pl	4	The state of the s	3-1		7522	Conno	llor D	Anatomy	/ Gif	ts Reg	istry , MD 21076	
Physician /Medica		23a. Part l failur	Enter the disease  List only one car	, or compli	cations that caused the	e death. Do n	ot enter the m	ode of dying,	such as cardia	ac or respiratory a	rrest, sho	ck, or heart	Approximate Inte	) erval
Examine		Immediate or condition	Cause (Final disea n resulting in death	ase a. C	Complications of I	Right Parie	etal Lobe E	Bleed					Between Onset a Death	and
	١.	Sequentia	ly list conditions,	у b.	ue to (or as a consequ	ence of):								
	iner	if any, lead	ling to immediate for Underlying Cau	50	ue to (or as a consequ	ence of):								
Si d	Examiner	(Disease of events res	r injury that initiate ulting in death) Las	d c st D	ue to (or as a consequ	ence of):								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit			ENDED	d [X]									1	
760, cate be ex physician the burial.	Medical	IF FEMALE			*5,10	e,perl	FH,G928	6/29	<u>/2012</u> ,w	S				
687 sertifica ding p		23b. Was de	ecedent pregnant in months?	n the	23c. If yes, outcome of	2	2 Fetal death 3 Fctonic pregnancy							
Box 687.  he death certification of the attending of the for use as the	Physician/	1 Yes	2 No 9 U	Jnknown	4 Pregnant at time	e of death 5	Other (					NOTIO!	Day Year	
P.O. Its that the gned by the detached		Part II. Oth	er significant cond	ditions o	ontributing to death bu	t not resulting	in the underl	ving cause gi	ven in Part I	23e Did t	obacco u	o cantributa la	the cause of death?	
S, P.C.	od by	Ends	tage Pancreat	ic Cance	er, Atrial Fibrillation	on, Corona	ary Artery I	Disease					the cause of death?  bably 4 Unknown	
Records,  The law require ficate has been si	Completed									24a. Was	an	24b. Were au	itopsy findings availat	ble
tal Reco	E										rmed?	prior to death?	completion of cause of	of
Division of Vital Records, P.O. Hopital or Attending Physician: The law requires that the fours after death.  Funeral Director: After this certificate has been signed by lely filled in by the funeral director, page 2 should be detach.	Be (	25. Was cas examine	se referred to medic		pital:			26 Place o	of Death (Chec		2 ✔ No	1 Ye	es 2 No	-
of Vitaling Physician: After this certiuneral director	£	1 Y 27. Manner		Inos	28a. Date of Injury		tpatient 3		Other Nurs	ing Home 5	Residenc	e 6 🗸 Other	: Scene	$\neg$
ion (tending eath.	틶	1 Natu	ıral 5 Per	nding	May 27, 2012	1200	ime of Injury hrs	28c. Injury	at Work? es 2 ✔ No	28d. Describe I Subject fell	now injury from st	occurred		$\neg$
Division tall or Attendin 13 after death.	ertification:	2 ✓ Acci		estigation	28e. Place of Injury	At home, far	m, street, facto							
Div apital or hours afte neral Dir filled in	S	4 Hom	icide det	ermined	(Specify) Reside			,,	nang, oto.	or Town, S 13111 Linden	tate) Church	Number or Rui Road Clarks	ral Route Number, Cit	ty
To the Hospi within 24 hour To the Funer completely fill	ical	29a. Certifie (Check only one)	Carrilying F	hysician:	To the best of my know	wledge, deat	h occurred at	the time, date	and place, an	al alconomic				$\dashv$
To with	Medical	29b. 8tgnatu	re and title of certifi	an	the basis of examinat d manner stated.	ion and/or inv	vestigation, in	my opinion, c	death occurred	at the time, date a	and place	, and due to the	e cause(s)	
		6	( , ,		, A		2	9c. License r O.C.M.				te signed (Mon	th, Day, Year)	$\neg$
		30. Name an	address of person	n who com	pleted cause of death	(Item 23a)					June 3	3, 2012 		
		Zabiull	ah Ali, M.D.	Assista	nt Medical Exami		W. Baltim	ore Street	, Baltimore	, MD 21223				$\neg$
Sta Registi		31. Date filed	(Month, Day, Year)		32. Region & Sid									$\dashv$
HMH 17 Rev 1/20			7000	<del>9                                    </del>	4 Janua	1	face							
CME 2006						ORIO	SINAL				OCHAE			

12-04185 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Frederick William Knubbe State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death June 2, 2012 Medical Examiner 1312 hrs 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death 9624 Baltimore Avenue Rm 112 College Park Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Hours Director 216-60-4167 1 VM 2 F Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9624 timore Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 V No Yes 4 Divorced If Yes, Give Year or Dates: White 1 Yes 2 No specify: Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager 17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22/24 ٥ Informant's Name/Relationship (Type, Print) 19b. Mailing Address it: If item 27 is nkton errace 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State timore. Burial 2 Cremation 3 Removal from State crematory or other place) 0 4 Donation 5 Other Specify ature of Funeral Service Licenses 22. Name and Address of Facility vell Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Approximate Interval **Physician** failure. List only one cause on each line tween Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown chronic alcoholism Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? page certificate ✓ Yes 2 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Other | Nursing Home | 5 | Residence | 6 | Other Scene Inpatient 2 ER/Outpatient 3 DOA ဥ 1 Yes No 28a, Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Division death. Pending 1 Yes 2 No the 2 \_\_\_ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after In the Funeral Dire 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be In the Hospital determined 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1/ Sh

DHMH 17 Rev 1/2001 OCME 2006

Registra

Name and address of person who completed cause of death (Item 23a)

32. Registrar Signatu

Theodore M. King, Jr., MD.

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

UUIVIE

June 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Charles Wayne Kelly, Sr. JUNG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death MEDICAL JUSEPH Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Country) Director 212-42-3678 66 1 □XM 2 □ F 12/11/1945 MD Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Jarrettsville 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 21084 3913 Boxwood Road 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XMarried þ 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 Divorced 4 Divorced Navy Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver A&S Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma B. Haar Raymond E. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3913 Boxwood Road, Jarrettsville, MD 21084 Mary Kelly - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 06/06/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of Examiner equantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ed by the atten edetached for u in the past 12 months? Year Dav Pregnant at time of death Yes 2 No g Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an certificate has b lirector, page 2 s autopsy prior to completion of cause of death? \_\_ Yes 1 L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident injury work?
1 Yes 2 No 5 Pending the 1 Investigation n 24 hou. **the Funeral Dire**د. مال filled in by th 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of o 29d. Date s

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Social Ronda		Redistrar	ertificate of		id Wichtai		g. No.	2 1821
Physici		Decedent's Name (First, Middle,Last)				Date of Death     Month	Day Year	3. Time of Death
edical Exami	ner	Rebecca Rondash			.1	June 3, 20	12	0628 hrs
		Facility Name (if not institution, give street and number)     St. Agnes Hospital	4	Baltimore	or Location of De	eath	4c. County of Deat	n
Funeral			s. last birthday)	If Under 1 Ye	ar If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		219-17-5357 1 M 2KF 32	Yrs.	Months Da	ys Hours !	Dec.21	` 1Forei	
w any		10a. State 10b. County 10c. Cit	ty, Town or Locatio	on				10d. Inside City Limits
yland -f sho	tor	10e. Street and Number		10f, Zip Code		1.0	000	1 Yes 2 No
h the Mar 3a or 28a iotified a	Director	2038 Harman Avenue		212	230	10	g. Citizen of What Cou USA	nuy?
b, MD 21215-0036 and 2 should be Fijed within 72 hours after death with the Maryland feath and Mental Figiene. ten 27 is marked other than "natural", or items 23a or 28a-f show fraumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 XNever Married 2 Married Armed Forces?  1 Yes 2 X No	If Ye	s, specify Cuba	an, Mexican, Pue	( Specify Yes or No- erto Rican, etc.)	14. Race - Ame White, etc.	ican Indian, Black,
rs after	Š	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		Yes 2 XXN	o specify: ation (Give kind	of work done	Specify: 16b. Kind of Business	White
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examine:	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			e. DO NOT use		16b. Kind of Business	industry
othin ar ther	mpl	10 0	disab1	ed			disable	d
Filed w Hygin d other		17. Father's Name (First, Middle, Last)				me (First, Middle, M	aiden Surname)	
212	To Be	Thomas T. Kondash  19a. Informant's Name/Relationship (Type, Print )	19b Mailing	Address (Stre		on Myers	per, City or Town, State	Zin Code)
AD 2 shound and 3 is martic	_	Thomas T. Kondash / Father		,			, MD 21230	,,
Te, F I and Health		20a. Method of Disposition 20b	o. Place of Disposit crematory or other	ion (Name of co			20c. Location - City of	
Baltimore, MD 21215-0036 etemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiers. Important: If them 77 is marked other than nijury or other traumatic event, the Medical		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	-		v.LLC 6	7/2012	Glen Burni	e. MD
Salti ermit. epartm nportu jury e		21. Signature of Funeral Service Licensee	22. Na	me and Addres	ss of Facility	mbrose Fu	Glen Burni neral Home	, Inc.
		23a. Part I. Enter the disease, or complications that caused the deal	13	28 Sul	hur Spr	ing Road	Arbutus, M	
Physician /Medical		failure. List only one cause on each line.					st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Complications  Due to (or as a consequence	of Pulm	onary H	yperten	sion		Death
		Sequentially list conditions, b						
	ine	if any, leading to immediate  cause. Enter Underlying Cause (Disease as injury that injuries	of).					
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence	of):					
xecute n and l - tran		d.    X UNPENDED   X AMENDED#5 per	FH C028	6/12/20	10 111			
60, ate be e hysicia e burial	Medical	IF FEMALE: 23b. Was decedent pregnant in the	e.2930 8	-14-12 <sup>0</sup>	sm 5 per	r fh g934	12-3-12 v	H
5876 rtifica ling ph		past 12 months?	2 Feta	al death 3	Ectopic pre	gnancy	Month 23d. Date of deliver	y Day Year
Vital Records, P.O. Box 68760, yaidan: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burnal - transit	Physician/	1  Yes 2 No 9  Unknown 9  Unknown	3 Otne	er (Specify)				
P.O. ss that the gned by	Š	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause	given in Part I.		acco use contribute to 2 ✓ No 3 ☐ Pro	
ds, equire:	Completed							itopsy findings available
to share of the state of the share of the sh	ď	-		<del></del>		autops	ned? death?	completion of cause of
Retificat		25. Was case referred to medical		26 Piac	e of Death (Che	1 Yes 2	No 1 <b></b> Y	es 2 No
Vita hysicla this cel	To Be	examiner?  Hospital: 1 Inpatient 2	✓ ER/Outpatient		Othor -		tesidence 6 Othe	
n of Vital ding Physician: After this certif		27. Manner of Death 28a. Date of Injury	28b. Time of Inj	ury 28c. Inji	ury at Work?	28d. Describe ho	w injury occurred	
Vision or Attend fler death. Director: in by he f	atio	2 Accident Investigation			Yes 2 No			
Division of Vital Records,  To the Hospitalor Attending Physician: The law require within 24 hours flet death. To the Funeral Director: After this certificate has been s completely filler. in by he funeral director, page 2 should the	Certification:	3 Suicide 6 Could not be determined (Specify)	home, farm, street,	, factory, office	building, etc.	28f. Location (St or Town, Sta		ral Route Number, City
Hospit 4 hour Funers		4 Homicide (Specify)  29a. Certifier (Check only 1 Certifying Physician: To the best of my knowle	edge death occurre	ed at the time of	late and place a	and due to the cause	(s) and manner as stat	ed
o the lithin 2 o the l	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.					• •	
E 3 E 8	₩ W	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)
		Teiprell/ Withell, M)		0.0	.M.E.		June 4, 2012	
Sant.		30. Name and address of person who completed cause of death (Ite Pamela E. Southall, MD Assistant Medical Ex		M/ Politima	ro Stroot D	oltimore MD 041	223	
P	ate	Pamela E. Southall, MD Assistant Medical Ex  31. Date filed (Month, Day, Year) 32. Aegistrar's Signa			ie olieet, Ba	uumore, MD 212	223	
St Regist		MINI 0 8 2012 / Lever	B. Back	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Edward Little June 6:33 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 504 Beck Avenue Baltimore Essex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months (Month, Day, Year) Days Hours 431 03 0247 Director 1 ፟M 2 □ F 93 Yrs Sept. 18, 1918 Arkansas 28e-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumetic event, the Medical Examiner must be notified at Direct Maryland Baltimore Essex 1 ☐ Yes 2 K No 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral or items 23e 504 Beck Avenue 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 19
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 White 1942/69 1 ☐ Yes 2X No Specify: "neturel", Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 on the Mental Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Air Force Pilot 5+ æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Little Clara Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 si of Heelth e Item 27 i Letitia L. Morgan (Daughter) 504 Beck Avenue Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1
Depertment of
Importent: If it
eny injury or o 1 Burial 2 A Cremation 3 Removal from State Bayview Crematory Inc. 6/8/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex 21. Signature of Funeral Service Licens Maryland 21221 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line Immediate Cause (Final STAGE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 2 🗆 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Xcertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 2012 Y 30. Name and addre erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Loney,	Jr.	S 1- For State Registrar	tate of Marylan		artment o		d Mental I		eg. No. 201	2 1821	
Physici Medical Exami		1. Decedent's Name (First, Midd	Loney	TR.			-	2. Date of Dea Month May 31, 2	th Day Year	3. Time of Death 1014 hrs	
		4a. Facility Name (if not instituti	on, give street and numb	oer)		4b. City, Town, or I			4c. County of Dea		
Funeral		Potomac River at For  5. Social Security Number			yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. [			rs 8 Date of Bir	Prince George's  B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or		
Director		216-84-4790		, ig = ( )	39 Yrs	Months Dave		. ,	/ For	eign Country) MD	
any		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Locat	ion		-		10d, Inside City Limits	
▶	<u>-</u>	MD		1 1	Baltil					1 Yes 2 No	
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		1		10f. Zip Code		1	0g. Citizen of What Co	puntry?	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once		11. Marital Status	N6Wood	HVEN	UE 13 Wa	2/2 s Decedent of Hisp		Canaife Van as Na	USA	oriona la dina Dinak	
leath w	Funeral	1 Never Married 2 M		es? 2 🔀 No		es, specify Cuban,			White, etc.	erican Indian, Black,	
s after c	by F		vorced If Yes, Give Year or Dates:			Yes 2 No			Specify: ${\cal B}$		
	eted	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>				t's Usual Occupationst of working life.			16b. Kind of Busines		
5-0036 led within 72 hou Hygiene. other than "nat	Completed	12	3		Tech	Superi			COMCas	+	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Cc	17. Father's Name (First, Middle Charles Lor					8.Mother's Nam	ne (First, Middle, M Mae K	Maiden Surname)		
D 2121 should be fil and Mental I 7 is marked natic event,		19a. Informant's Name/Relations	ship (Type, Print)	LEC	19b. Mailing	Address (Street	and Number or	Rural Route Num	ber, City or Town, Sta	te, Zip Code)	
<b>∑</b> 2 d d d d d d d d d d d d d d d d d d		Vanessa J. 1 20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b.	Place of Dispos	tion (Name of cem	etery,	Date Date	alto, MD	or Town, State	
MOF6 Pages 1 ent of Fi		1 Burial 2 Cremation 4 Donation 5 Other S		State G	crematory or oth A <i>rden</i>	erplace) of Gait	6	113/12	Baltin	nore, MD	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signal fre of Funeral Service	Licensee		22. N	ame and Address	of Facility Va	MIGHN 6	REENERUN	ERAL SCKS	
Physician	. 10	23a. Part I. Enter the disease, or	complications that caus	ed the death	. Do not enter th	e mode of dying, s	K Koad auch as cardiac	or respiratory arre	est, shock, or heart	2/2 Approximate Interval	
Medical Examiner		failure. List only one cause Immediate Cause (Final disease	a. Drowning							Between Onset and Death	
· · · · · · · · · · · · · · · · · · ·		or condition resulting in death)	Due to (or as a co	nsequence o	f):						
	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence o	f):						
1 8 E	Examine	(Disease of Lijury that hilliated events resulting in death) Last	Due to (or as a co	nsequence o	f):	<del>.</del>					
be executed ician and urial - transi	dical	■ UNPENDED	d AMENDED 23	Ba,27,2	28a-f,pe	er me,g92	8 6-12-	-12 sm			
		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outo		nancy				23d. Date of delive	ry	
Box 68760 e death certificate b the attending physi ed for use as the bu	Physician/Me	past 12 months?	4 Pregnant	at time of de	ath -	aldeath 3 _ er(S <i>pecify</i> )	Ectopic pregn	ancy	Month	Day Year	
Bo he deat y the at hed for	hys		(nown g Unknown				:- B-11	Loo- Distan		Marana di danino	
s, P.O. B ires that the do signed by the 1 be detached 1	<u>a</u>	Part II. Other significant condit	contributing to de	ath but not re	esuiting in the ui	nderlying cause giv	en in Part I.		bacco use contribute to	bably 4 Unknown	
ords, w require is been si should b	Completed							24a. Was a		utopsy findings available	
Aeco	dmo				· <del>-</del>	_		autops perform 1 ✓ Yes 2	med? death?	completion of cause of	
tal Rection: The certificate ector, page	Bec	25. Was case referred to medical examiner?					f Death (Check	only one)			
n of Vital Rec Jing Physician: The I After this certificate I funeral director, page	라	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatient 28b. Time of In				Residence 6 🗹 Othe ow injury occurred	er: Scene	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter deat all birector. After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	1 Natural 5 Pend	FOUND: Day	y,Year)	FOUND: 1000 hrs		s 2 X No	subject	tumped of	bridge into	
ivisio I or Atter after deat Director	tifica	3 X Suicide 6 Coul	d not be 28e. Place of	Injury - At ho		, factory, office bui	lding, etc.	or Town, St	treet and Number or R	ural Route Number, City	
Di Iospital 4 4 hours a funeral I		29a. Certifier	mined (Specify) R		ne death occur	ad at the time, date	and place, and	Ox	on Hill,MD	•	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after deat.  To the Funeral Director After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b			miner: On the basis of example and manner state	kamination ar							
	ž	29b. Signature and title of certifie	r			29c. License			29d. Date signed (Mo	onth, Day, Year)	
5	-	30. Name and address of person	who completed cause of	f death (Item	23a)	O.C.M	.C.		,		
9 peru		Assistant Medical E	·			ltimore, MD 21	1223				
Sta Regist	_	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	re						
		VUIT V V AVIA	Down B.	Louis	Co						

12-04249 Richard Lyons

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Lyons	1- For State Registrar	tate of Maryla		artment o rtificate o		d Menta	al Hyg		eg. No.	20	12	1821
Physician/	1. Decedent's Name (First, Mide	ile,Last)			_			Date of Deat Month	Day	Year	3	3. Time of Death 1906 hrs
Medical Examiner	Richard Jo  4a. Facility Name (if not instituti				4b. City, Town, or	Location of		June 4, 20		. County of [	Death	1900 1115
	10508 Faulkner Ridg		nber)		Columbia	Location of	Deatti			loward	Journ	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under	24Hrs.	8. Date of Bin	th (MM/			place (State or
Director	219-64-8445	1 X M 2 F		57 Yrs	Months Days	Hours	Min.	April	8,1		oreign Cour	itry) DC
	Usual Residence of Decedent											
A any	10a. State 10b. County			Town or Locat	ion						- 1	1 Yes 2 XNo
land fishov	MD Howar	d	Col	umbia								
the Maryland a or 28a-f show any tiffed at once. Director	10e. Street and Number				10f. Zip Code			1	0g. Citi	zen of What	Countr	у?
th the 23a o	10508 Faulkne		rcle edent Ever in U	C 142 W	21044 as Decedent of His		2/5000	ify Vac or No	USA		America	an Indian, Black,
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 N	Married Armed Fo	rces?		es, specify Cuban					White,		arr ardan, black,
", or cr mu	3 Widowed 4 XXDi	1 Yes vorced If Yes, Give Year	2XX No	1 🗆	Yes 2X No	specify:				Specify:	Whi	te
ours afte	15. Decedent's Education (Sp.	or Dates: ecify only highest grad	le completed)		nt's Usual Occupat				16b. l	Kind of Busin	ness/Ind	dustry
6 72 h cal En	Elementary/Secondary (0-12					DO NOT U	se retiret	-,	D .	etail		
5-0036 led within 72 hours lygiene. wither than "natur the Medical Exam Completed	17. Father's Name (First, Middle	2		Sales	·	19 Mothor's	Name /E	irst, Middle, N				
21215-0036 build be filled within 7 Mental Hygiene, marked nither than cevent, the Medica	Victor Herbe							ustine				
212 ould be d Ment in mark	19a. Informant's Name/Relation			19b. Mailin	g Address (Stree						State, 2	Zip Code)
MD and 2 should hand and 27 is	Lorraine L. S	cheib/ Sis			Ridgefie		_	·				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	20a. Method of Disposition  1 Burial 2 XX Crematic	n 3 Removal fro		Place of Dispos crematory or ot	sition (Name of cer her place)	netery,		Date	20c.	Location - C	ity or T	own, State
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr	4 Donation 5 Other 8	Specify:		est Aru	ndel Crem	n	2	2012	Ođ	lenton	, M	D
Salti emit. epartn nport	21. Signature of Funeral Service		.01050		Name and Address		Dona	aldson	Fun	eral :	Home	e, P.A.
	294. Part I. Enter the disease, of		101053		L3 Talbot							Approximate Interval
Physician /Medical	failure. List only one caus	e on each line.					4.00	ophare, yan				Between Onset and Death
Examiner	Immediate Cause (Final diseas or condition resulting in death)		consequence o		iovascular Dis	ease					-	۰.
	Sequentially list conditions,	b										
iner	if any, leading to immediate cause. Enter Underlying Cause	9	consequence o	of):								
be executed ician and inial - transit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):								
O,  e be executed sician and burial - transit edical Ex		d									-	
	UNPENDED	AMENDED					_					
Division of Vital Records, P.O. Box 6876/ tal or Attending Physician: The law requires that the death certificate its after death.  al Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the b artification: To Be Completed by Physician/Ma	IF FEMALE: 23b. Was decedent pregnant in		outcome of preg irth		etal death 3	Ectopic p	oregnand	y	23	<ul> <li>d. Date of de</li> <li>Month</li> </ul>	elivery Da	y Year
). Box 6876 the death certificate by the attending phy ched for use as the Physician/M	past 12 months?		ant at time of de	noth -	ther (Specify)							
Bo le deat the at the at	1 Yes 2 No 9 U	nknown 9 Unkno						Dog Did to		contrib.	to to th	e cause of death?
P.O. that the med by detach			death but not r	esulting in the	underlying cause g	liven in Part	1.		_		,	bly 4 🗸 Unknown
duires en sig uld be		Holesterolerina					_	24a. Was	an	24b. We	ere auto	psy findings available
Records, The law requires fricate has been sig				-		_	_	autop perfo	sy rm <u>ed</u> ?	prid		mpletion of cause of
Rec ficate Con				·	26 Diago	of Death (C	Shook on		2 🗸 N	lo 1 L	Yes	2 No
ician s certi rrector	25. Was case referred to medic examiner?	I I a a a it a la sussession	npatient 2	ER/Outpatien		Oth			Reside	ence 6 🗸	Other:	Scene
of Vital Recing Physician: The After this certificate After the Corp. page 70 Per 70 P	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of		ry at Work?		8d. Describe				
on on ath.		nding	, Day,Year)		1 1	res 2 1	Vo O					
Visi or Att fter de in by i		estigation 28e. Place	e of Injury - At h	ome, farm, stre	et, factory, office b	uilding, etc.	2	8f. Location (		and Number	or Rura	al Route Number, City
Division o spital or Attending nours after death. neral Director: After filled in by the func	4 Homicide det	ermined (Specify)							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the bes										
To the Ho within 24 To the Fu completely	one) 2 Medical Ex	and manner s		and/or investige	29c. Licens		arrod at t	ano timo, dato				h, Day, Year)
2	200. Signature and title of certif	0			O.C.1				1	ne 5, 2012		,,,
	30. Name and address of person	un who completed cours	se of death /Iton	n 23a)						-,		
100		Assistant Medica			altimore Stree	t, Baltimo	ore, Mi	D 21223				
State	31. Day (10/8, 2012	) 32. Re	gistrar's Signa	ure Kel								
Registra	JUN U O 2012	cenera	14. 19									

DHMH 17 Rev 1/2001 OCME 2006

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 June Christina Littleton 2:20  $A^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 14928 Waterway Drive Montgomery Rockville Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) Months Hours Country) 466-56-9042 **Director** 75 1 M 2 X F Yrs June 6, 1936 Texas Usual Residence of Decedent 28a-f show 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Rockville 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? by Funeral 23a 14928 Waterway Drive 20853-3640 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ō Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I marked o မ Louis Kubacak Emma Α. Policak 1 and 2 should be of Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14928 Waterway Drive, Rockville, Maryland 20853 David A. Littleton / Husband injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June Date 11. X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Linensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Carry Peter Brand M01305 23a. Part 1. prt. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Approximate Interval Between
1 Ponset and Death
2 Years Immediate Cause (Final Physician/ Primary Peritoneal Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be 68760 as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Po Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinson's Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 K No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2 **X** No ပ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 🗶 Natural 5 Pending Accident
Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 June 5, 2012 900 ne and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, 2730 University Blvd., West #400, Wheaton, Maryland 20902 M.D. 32. Registrer's Sign State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Pear Physician/ 5, 8:25 PM June Bao-Thuan Thi Luu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1921 June 10, Days Hours Min. Vietnam 90 217-45-5781 Director Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Rockville 1 Yes 2 X No Maryland | Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20852 6121 Montrose Road Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Tai Dang Cat Luu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11701 Virginia Pine Drive, Germantown, Maryland 20876 Lan Nguyen / Daughter 20a. Method of Disposition
1 □ Burial 2 █ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State June 2012 Bethesda, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Rumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Dementia resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be exitin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending inhusing IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 1 Z Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

29b. Signature and title of certifier minor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazli,

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

6/21

Montrose

D0064871

Rackville

		Please	Type or Print in				-	_	gible.	
		For State Registrar	State of Marylan		irtment of F tificate of D		-	giene <sub>Reg. No.</sub> 2	112	18220
Physic		1. Decedent's Name (First, Middle, Las William	·	ash			2. Date of Dea Month	Day	Year	3. Time of Death  G: 45 AM
Med Exam		4a. Facility Name (if not institution, give		E	4b. City, Town, or	Location of Death		4c. County		
Funera Directo		Social Security Number     6. Security Number			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Yea <i>r</i> )	9. Birthpla Country	
and show at	o.	Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc	ation		reb ZZ	, 1928	Nebra	d. Inside City Limits
e Maryla r 28a-f notified	Director	MD Balt  10e. Street and Number	imore	Pike	sville		1	40 02	NA#2	1 🗆 Yes 2 🕅 No
n with th ns 23a o nust be	Funeral	1840 Reisterstow	n Road			1208		10g. Citizen of U.	S.A.	y? 
irs after death ural", or item I Examiner n	þ	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	H	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 <b>X</b> No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americar ck, White, et :: Whi	c.
be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occupa ind of work done of NOT use retired) Manager		king	16b. Kind of B	ss Sta	
d be filed Mental Hy Arked oth	To Be	17. Father's Name (First, Middle, Last)  Louis Roy	Lash			18. Mother's Nan		Maiden Surnam <b>bel</b>	Robb i	ns
and 2 should be file Health and Mental Hear s is marked of the traumatic eve	1	19a. Informant's Name/Relationship (Ty Margery A. McInto		T	g Address (Street a					de)
		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	lace of Disposemetery, crem	sition (Name of atory or other place	e)	Date 5/12	20c. Location	- City or Tow	n, State
permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licens	,		Name and Addres	s of Facility Ru	ck Towso	n Funer	al Hom	ne, Inc.
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or		n. Do not ente	1050 York				1	Approximate nterval Between
Phytician Medica	_	Immediate Cause (Final disease or condition resulting in death)			iemorrh f	AGE				Onset and Death OAYS.
Examine		Sequentially list conditions, if any, leading to himseliate	b. AMY LOLD P		ATHY					EARS.
ecuted and Il-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ience of):						
E is	dical		d							
Attending Physician: The law requires that the death certificate be sr death.  ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No g   Unknown	23c. If yes, outcome of pregna 1  Live Birth 2  Feta 4  Pregnant at time of c	Ideath 3	Ectopic pregnanc Other (specify)	у			ate of delivery	y Day Year
es that the igned by be detact		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.				cause of death?
w require s been si	oleted by	RIGHT IIIT (STEC	מואו ואון ואון ואוון	<u>.</u>			24a. Was	an 24b.	Were autops	bly 4 Unknown  y findings available
n: The law ficate has or, page 2	e Compl	25. Was case referred to medical			00 PI	CD and COlor	1 Tyes	rmed?	prior to come death? 1  Yes 2	pletion of cause of
Physician: this certific	To B	examiner?	Hospital:	ER/Outpatien	t 3 □ DOA Othe	4 L Nursing H	ome 5 Resid			
tending Ph leath. or: After th the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	injury	28c. Injury work' M 1		28d. Describe h	ow injury occurr	red	
> 7 # # E		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural R	oute Number,
To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check 2 Medical Examin	ician: To the best of my knowl ner: On the basis of examination e Practitioner: To the best of m	and/or invest	gation, in my opinio	n, death occurred a	at the time, date a	nd place, and du	e to the caus	e(s) and manner stated.
To the Complex		29b, Signature and title of certifier	Gary, PG-1-	1, 1986	29c. License	number		29d. Date signer		
3		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, P	rint)		RE. 2401			
Sta Regist	ate	21 Data filed (Month Day Year)	32 Registrar's Signat				-, -, -,	MO	- 21215	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
negisi	Tal	<b>JUN</b> 0 0 20	- Comment	7						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMND ITEM#8perFH, 6938, 4722/2013, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 337AM MAY **Physician** Ann Logan, 28 2012 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 1/28/19659. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F 46 Maryland 217-94-2616 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 □ No Director MD Baltimore Essex 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or "natural", or items 23a or U.S.A. 421 Dorsey Avenue 21221 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes Yes 1 X Never Married 2 ☐ Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Year or Dates Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail 9 Cashier 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Elisabeth Altvater Anna ည Richard Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 421 Dorsey Avenue, Essex, MD 21221 <u>Staci Logan / Daughter</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State injury or Department Important: If any injury or once. 06/04/2012 | Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Fu eral Service Licen 22. Name and Address of Facility Anatomy Gifts Registry N V 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) ity percarbic respiratory failure **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed COPD Due to (or as a consequence of): Box 68760, Physician/Medical as attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ■No detached for 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 No 3 Probably 4x Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 Inpatient Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation Injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29c. License number RES - 000 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-MD May 28,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenie Shieh

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2012

11595

**ORIGINAL** 

Bove S. facel

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

12-04250

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

anice Lee		S 1- For Stete Registrar	tate of Marylan		ment of icate of		d Mental I		eg. No.	2012	2 1822
Physicia Medical Exami		1. Decedent's Name (First, Midd	E. Lee					2. Date of Dea Month June 4, 20	ith Day	Year	3. Time of Death 2150 hrs
,		4a. Facility Name (if not institution  Mercy Medical Cente		per)	41	b. City, Town, or Baltimore	Location of Dea	ath	4c. C	ounty of Death	
Funeral Director		5. Social Security Number 214 58 9421	6. Sex 7.	Age (In yrs, last I	birthday) Yrs.	If Under 1 Year Months Days		in. Jan	195 a	Foreig	thplace (State or in untry)
Maryland 28a-f show aoy d at oocc	or	Usu'al Residence of Decedent  10a. State 10b. County  MD NA		10c. City, Too Batti		n					10d. Inside City Limits  1 Yes 2 No
ith the Maryland 23a or 28a-f sho ootified at ooce.	<b>Funeral Director</b>		dle St.			10f. Zip Code 21203			15A	of What Cour	
r death w	by Funera		larried 12. Was Deceded Armed Force 1 Yes  vorced If Yes, Give Year or Dates:		If Yes	Decedent of His s, specify Cuban res 2 No		Specify Yes or No to Rican, etc.)		Race - Americ White, etc.	can Indian, Black,
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be coeffied at once	Completed b	15. Decedent's Education (Spe Elementary/Secondary (0-12)			during mos	Usual Occupation of working life.	ion (Give kind o DO NOT use re	etired)		of Business/II	•
Baltimore, MD 21215-0036 cemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than injury or other traumatic event, the Medica	Be	17. Father's Name (First, Middle Allen Lee					Sarah	ne (First, Middle, I	all	·	
ore, MD 2 ss 1 and 2 shoul of Health and IN If item 27 is m	٩	19a. Informant's Name/Relations Dartego A. L.  20a. Method of Disposition	ee - Son		906 i	E · Bidd	le St.	Rural Route Num Balto. M	no 8	11202	
MOFE Pages 1 nent of H nnt: If i		1 Burial 2 Cremation 4 Donation 5 Other S, 21. Signatur of Funeral Service	pecify:		atory or othe	emetery	6-	Date 12-12		ation - City or	
= ====		23a. Part . Enter the disease, or	me	and the death Da	Gary	ne and Address	hFH27	o Fredhili	tonfox	c Posto	mo 21229
Physician /Medical Examiner		failure List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	e Intoxi			such as cardiac	or respiratory arr	est, snock,	or neart	Approximate Interval Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):							
cuted und transit	Exami	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):							
be executed sician and urial - transi	edical	X UNPENDED	a.  AMENDED 23	a,27,28a	-f,per	me,g92	8 6-12-	12 sm			
Division of Vital Records, P.O. Box 68760, the Hospital or Atteodiog Physician: The law requires that the death certificate be execut thin 24 hours after death.  Ithe Fuorral Director: After this certificate has been signed by the attending physician and opplietely filled in by the funeral director, page 2 should be detached for use as the burial - transfer.	žΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unk	1 Live birth	at time of death	2 Fetal	death 3 [	Ectopic pregr	nancy	23d. D Mo	ate of delivery nth D	ay Year
res that the signed by the detache	<u>6</u>	Part II. Other significant conditi	ions contributing to de	ath but not result	ing in the und	lerlying cause gi	ven in Part I.			_	he cause of death?
Division of Vital Records, P.O tal or Atteodiog Physician: The law requires that the safer death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	Completed							24a. Was a autop perfor	sy med?		opsy findings available ompletion of cause of
Vital Rechysician: The this certificate	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Manufact.	itient 2 🗸 ER/	Outpatient 3		of Death (Check	only one)	Residence	6 Other:	
sion of A treodiog Ph death. ctor: After tl y the funeral	ation: To	27. Manner of Death 1 Natural 5 Pend	28a. Date of In (Month, Date of In (Month, Date of In (Month) Date of	y,Year)	o. Time of Inju	ry 28c, Injury	es 2 X No	28d. Describe h			
Divis	Certification:	4 Homicide deter	d not be mined 28e. Place of (Specify)	Injury - At home, Resi	farm, street, dence	factory, office bu	uilding, etc.		tate) 506	Caller	al Route Number, City nder Street
Divisior To the Hospital or Atteod within 24 hours after death To the Ruorral Director: completely filled in by the	edical	one) 2 Medicai Exam	nysicien: To the best of miner:On the basis of ex and manner state	xamination and/or		ı, in my opinion,	death occurred		and place,	and due to the	cause(s)
		29b. Signature and title of certifie  30. Name and address of person	mll Mo	f donth (Itam 22a)		29c. License O.C.N			June 5	signed (Mon	th, Day,Year)
		Melissa Brassell, MD	Assistant Medic	al Examiner	,	Baltimore St	reet, Baltime	ore, MD 2122	3		
Sta Registr	333	31. Date filed (Month, Day, Year)	<b>b</b> 2012 32. Regist	rar's Signature	1 pa	Kel					
DHMH 17 Rev 1/20 OCME 2006	01	OCME	/	O	RIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monto 6 :50Pm James Louis Mead Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death oastil WICOMIC Hospice at Social Security Number If Under 1 Year If Under 24 Hrs ... B. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Month, Day, Ye Sept. 24, Days Maryland 216-34-1888 Director 1 X M 2 □ F 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other then "netural", or items 23a or 28a-f sho any injury or other treumatic event, the Medical Examiner must be notified at 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 ☐ No Marvland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Pacific Ave. 21804 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 XX No Specify: 3 Widowed 4 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) accountant city of Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Anthony Mead Sr. Anna Neary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Hamlet Hill Rd., Robert L. Mead/brother #1114 Baltimore, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Green Mount Crematory June 5,2012 21. Signature of Funeral Service License Mitchell-Wiedereld Funeral Home York Rd 6500 Baltimore, 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION NEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner CRREBROVAS CUL Sequentially list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funerel Director: After this certificate has been signed by the attending should be a signed burs after death. erei Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Pother (Specify) (SD) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00058410 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARIS 0 8 2. Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month <sup>Day</sup> 2012 Physician/ Ann Murphy June 4 2:53 Joyce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson . Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 **Funeral** Hours 219-36-1225 Usual Residence of Dece Director 1 🗆 M 2 💢 F Dec. 27,1941 Maryland 70 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** notified or 28a-f 1 ☐ Yes 2X No Maryland Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 21087 U.S.A. 7323 New Cut Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iter edical Examiner Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed White marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Russell Martin Dorothy Rodgers Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kingsville, Maryland William Murphy Former Husband 7323 New Cut Road 20b. Place of Disposition (Name of Meadlow Fielding or other place) Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-8-2012 Elkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) Si rate of Furieral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 1050 York Road 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached fo g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Certificate: To 1 Yes 2 No I Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No i 24 hours after death e Funeral Director: A letely filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 5, 2012 2:30  $P^{M}$ Kirsten Ursin Mansfield Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5633 Lambeth Road Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months **Director** 552-62-5504 1 M 2 X F February 27, 1938 74 England Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5633 Lambeth Road 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self-Employed Antiques Dealer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Johnny Ursin Emma Tenneson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr William H. Mansfield/Husband 5633 Lambeth Road, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 2012 21. Signature of uneral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Tools MO1360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Breast Cancer to Brain disease or condition Months Medical resulting in death) Years + **Examiner** Prior Stage II Breast Cancer Months Sequentially list conditions, Examine if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 2 X No ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has 2 🗌 No ☐ Yes 2 🗓 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 1 ☐ Yes 2 🗓 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After (Month, Day, Year) XNatural injury 5 Pendina death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director;

completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ature and title of certifier 29b. Sia June 6, 2012 0 O D37236 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn Hendricks, M.D. 6410 Rockledge Drive, Ste. 506, Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State faces JUN 0 8 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g928 6-8-12 vt
State of Maryland / Department of Health and Mental Hygiene Amend 10g, 17, 18, per INF, g943 9-17-13 sm
Certificate of Death
Reg. No. 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 3. Time of Death Physician/ Month Day 130 am ANEZOULA MASTROVASILIS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 7214 CONLEY STREET If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours GREECE **Director** 1 M 2 XF 214-94-0547 Usual Residence of Deceden 53 Yrs 12-31-1958 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director BALTIMORE 1X Yes 2 ☐ No MD. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7214 CONLEY STREET 21224 Greece USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER HOME 8TH Be 7. Father's Name (First, Middle, Last)
Michael Thetekous
MICHAEL THEJEKOUS 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 Is marke any Injury or other traumatic . ODGE. SOFIA DIAKANTONIS (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7214 CONLEY STREET BALTO. MD. 21224 MIKE MASTROVASILIS SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OAKLAWN CEMETERY 6-6-2012 BALTO.MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 13 6224 EASTERN AVENUE BALTO.MD. 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 6876 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Anezoula Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 XNo 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2/1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur Division Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19-5-12 1,001042 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linden Av But 410. 2120 31. Date filed (Month, Day, Year) 32. Egistrar's Signature State S D NUL Registrar

Cheryl Madden Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 3, 2012 **Medical Examiner** 2210 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3113 West Belvedere Avenue Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) Months Davs Hours Director 21394 0369 1 M Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygone.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country 837 Seaa USA 21225 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes Specify: Black 1 Yes 2 No specify: 4 Divorced If Yes, Give Year ੬ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than Baltimore, MD 21215-0036 usnier 18. Mother's Name (First, Middle, Maiden Surname Hmos Madden Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) racy mode Balto mo 21225 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other Specify rematory 21. Signature of Fqneral, Service Licenses H270Fraghiltonf Physician Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hi Between Onset and /Medical aHeroin and Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g928 6-12-12 sm attending physician or use as the burial -**X** UNPENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Cocaine Use Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending 1 Yes 2 X No unknown fd 09:30 pm fd 6-3-12 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3113 West Belvedere Ave. Baltimore, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined Found: Residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 4, 2012

State

31. Date filed (Month, Day, Year) 32.

Russell Alexander MD.

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature
ORIGINAL

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:00 a.M 2012 avenc Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ommon Birthplace (State or Foreign Country) 8. Date of Birth If Under 24 Hrs. 7. Age (In yrs. last by **Funeral** Min (Month, Day, Director 1 ☑M 2 □ F or 28a-f show e notified at ina State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Ses 2 No timore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 2 Nu items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n Was Decedent Ever in U.S. Armed Forces?
1 ✓ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) a O YE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ eterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur uneral Service Licensee 22 Name and Address p Russ Hone, P. A Facility uneval Part 1 Enter the shock, or heart fa disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate failure, List only one cause on each line Interval Between Immediate Cause (Final Physician/ ears disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Euguentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death signed by the at 2 No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

TVIATION

who completed cause of death (Item 23a) (Type, Print)

Signature

	E
Records, P.O. Box 68760	Cottono of attachtact attach out to the section of
Vital	buojojon.
of	0
ivision	ibandin
Ω	Longital
	To the L
	- 2

			Please Type or Prin				-	_	ible.	,
		•	For State of Mal	,	epartment of H Certificate of D			eg. No.20	12	18229
			1. Decedent's Name (First, Middle, Last)		<del>, , , , , , , , , , , , , , , , , , , </del>		2. Date of Death	h	Your Van	3. Time of Death
-	Physicia Medio	al	NICHOLAS ANTHONY PORTE	RA ————			June_	5, 2	012	5:02 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)  Greater Baltimore Medic	al Can		Location of Death  TOWSO	n	4c. County Bal	timo	re
	Funeral Director		5. Social Security Number 6. Sex 7. Age (216–30–9892 XX M 2 $\square$ F 78	In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/22/19	Year)	9. Birthp Count	lace (State or Foreign
	ind show at	۱	Usual Residence of Decedent	10c. City, Town of	or Location				1	Od. Inside City Limits
	Maryla 28a-f otified		Maryland Baltimore	Luthe	erville					1 ☐ Yes XX No
	/ith the 23a or st be n	ral D	10e. Street and Number 13 Alderman Court		10f. Zip Code <b>21</b>	093	1	0g. Citizen of \	What Coun <b>SA</b>	try?
36	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Fune	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever Arread Forces?  1 News 2 News 2 News 3 News 3 News 4 N	o Korea	13. Was Decedent of His If Yes, specify Cubar 1  Yes 2 XXIo		ecify Yes or No- Rican, etc.)		e - Americ ck, White, e	
21215-0036	Phours "natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. E	Decedent's Usual Occupa Give kind of work done d	ation Juring most of work	ina	16b. Kind of B	usin <b>e</b> ss/Ind	lustry
121	led within 72 Hygiene. other than " ent, the Me	Com	Elementary/Secondary (0-12) College (1-4 or 5+)	i ji	fe. DO NOT use retired)  Owner	3		Resta	urant	
	be filed w ental Hygi rked other ic event, i	Be	17. Father's Name (First, Middle, Last) Anthony Portera			18. Mother's Name Theresa		faiden Surnam	∋)	
Maryland	d 2 should be file alth and Mental I 127 is marked o er traumatic eve		19a. Informant's Name/Relationship (Type, Print) Anthony J Portera S	on 20	Mailing Address (Street a	and Number or Rura	al Route Number, ad Parkto	City or Town, S On MD 2	1120 C	ode)
Baltimore,	Page 1 and 2 ment of Healt ant: If item 2 ury or other i		20a. Method of Disposition 1 ☐ Burial XXX Cremation 3 ☐ Removal from State	20b. Place of L cemetery,	Disposition (Name of crematory or other place unt Cremato	e) 06 /06		20c. Location	-	wn, State
altir	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  2/ ignature of Funeral Service Licensee	Greenwo		-				al Home Inc
m	Dep June any		Jennis Dupkon Kenak	15	6500 York	Road Balt	imore, 1	Marylan		
- II)	Pnysician Medical				ascular			st,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, b. Sue to (or as a cause. Enter Underlying	tur Sequence of)						
	iath certificate be executed attending physician and for use as the burial-transit	al Examiner	that initiated events	consequence of	;				•	
92	icate b g physical	Medic	d							
. Box 68760	that the death certificate be ned by the attending physici e detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	Fetal death	3  Ectopic pregnanc 5 Other (specify)	у			te of delive	ery Day Year
s, P.O	v requires that the states is been signed by should be detailed		Part II. Other significant conditions contributing to death but  OUTIC SHE WOST			ren in Part I.	23e. Did tob			e cause of death? pably 4 Lunknown
of Vital Records,	The law ate has page 2	Completed by	pulmonary hyper atrial fibrillate	tensi	ien		24a. Was ar autops perforr 1 \(\sum \) Yes	med?		osy findings available mpletion of cause of
ita	Attending Physician: or death. ector: After this certific by the funeral director,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Otho	ace of Death (Chec				
of V	g Phys er this neral di	te: To	27. Manner of Death 28a. Date of injury	28b. Tir	ne of 28c. Injury	4 ∐ Nursing Ho ∕at	ome 5 Reside 28d. Describe ho			
ion	tending I leath. tor: After the funer	Certificate:	2 Accident Investigation		M 1 🗆	Yes 2 No				
Division	al or Attend s after death I Director: A ed in by the t		4 Homicide determined 28e. Place of Injury building, etc.		n, street, factory, office		28f. Location (Sta City or Town		er or Hural	Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier  (Check 2 Medical Examiner: On the basis of exe only one)  3 Certifying Nurse Practitioner: To the	mination and/or pest of my knowl	investigation, in my opinic edge, death occurred at t	on, death occurred a	t the time, date an ace, and due to the	d place, and du e cause(s) and r	e to the car nanner as s	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier  CUMMIA SWI auto	100	29c. License	number	2	9d. Date signe	d (Month, l	Day, Year)
	. /		30. Name and address of person who completed cause of dea	ath (Item 23a) (Ty	29c. License DOR TOPE, Print) Charles	ff To	assin a	111	717	a d
	R √ Sta	te	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	· Con Lev	0110	00000	1000		~ /
	Registr		JUN 0 8 2012 Sentina	1. 1	arkel					

Pleas	se Type or Pri					_	le.
For State Registrar	State of M	aryland / Depa <i>Cer</i>	artment of F <i>tificate of E</i>			ene 3. No.2 ()	2   8230
Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
Jody	Scott Par	11			June	3 2012	3:00 A <sup>M</sup>
4a. Facility Name (if not institution, g				Location of Death		4c. County of D	Peath
Shady Grove Ad				kville		Mont	gomery
5. Social Security Number 252–39–3202		e (In yrs., last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. (ear)	Birthplace (State or Foreign Country)
Usual Residence of Decedent	1 X M 2 □ F	+/ : Yrs.			March 4,	1965 W	Vest Virginia
10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits
Maryland Mont	gomery	Boyds					1 ☐ Yes 2 🏋 No
10e. Street and Number			10f. Zip Code		10	g. Citizen of What	: Country?
18009 Black Gol	d Way		2084	1		United	States
11. Marital Status	12. Was Decedent E Armed Forces?	If	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No 1	☐ Yes 2 🕅 No	Specify:		0 16 -	White
15. Decedent (Specify only highes	t grade completed)	(Give k	lent's Usual Occupa kind of work done d O NOT use retired)	ation luring most of worki	ing 16	6b. Kind of Busine	ess/Industry
Elementary/Secondary (0-12)	College (1-4 or 5	0+)	· ·	Logistic	cs	Trucking	3
17. Father's Name (First, Middle, La	st)				e (First, Middle, Ma		
Calvin Coolidge	Pau1			Bever1y	Claire	Thomas	
19a. Informant's Name/Relationship	p (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Rura	al Route Number, Ci	ity or Town, State,	, Zip Code)
Thomas M. Paul	/ Brother		_	Cove, Mc			
20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		20b. Place of Dispose cemetery, crem Montgomer Crematori	sition (Name of natory or other place y	June 20	7,	Oc. Location - City	or Town, State  Maryland
21. Signature of Funeral Service Lice	ensee	M01305 300	Name and Addres	s of Facility phrey Funer		ckville, l	Inc. and 20850–2805
23a. Part . Enter the disease, or c shock, or heart failure. List on	omplications that caused	the death. Do not ente					Approximate
Immediate Cause (Final disease or condition resulting in death)		ration for a consequence of):  ointestina	neumo i	nia			Interval Between Onset and Death
rooming in death)	Due to (of as a	a consequence of):	0 610-	0			12 600000
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		ointestina a consequence of):	e pice				12 hours
Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for as a	a consequence of):					
resulting in death) Last	d.	s consequence oi).					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
Part II. Other significant condition	s contributing to death b	ut not resulting in the ur	, ,	en in Part I.			e to the cause of death?
morbid obesit diabetes type	I	J			24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
					performe 1 Yes 2		Yes 2 No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpatient	Othe	er;	o <i>nly</i> o <i>ne)</i> me 5 ☐ Residend	on 6 Other (C)	nacifyl
27. Manner of Death  1 Matural 5 Pending 2 Accident Investiga	28a. Date of injui (Month, Day	ry 28b. Time of	28c. Injury work	at	28d. Describe how		

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Be Completed by Physician/Medical Certificate: To

Medical

Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D OCC 4413 June 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Juanita Smith, MD 9901 Medical Center Drive, fockwille, Many lord 20850 Date filed (Month, Day, Year) 32. Registrar's Signature State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

DHMH 17 Rev 06-2011

27. Manner of Dear 1 Matural Accident

3 ☐ Suicide 4 ☐ Homicide

6 Could not be

determined

Director

Completed by Funeral

Be

မ

Physician/ Medical

**Examiner** 

**Funeral** 

**Director** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b f Per INF G928 6/22/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 **Physician** 1:00 P M June Violet Lorraine Phillips /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Collington Episcopal Lifecare Community Bowie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep.30,1912 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🖔 F Kansas **Director** 579-10-3630 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at Mitchellvile North Bethesda 1 ☐ Yes 2 ☑ No Prince George's Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10450 Lottsford Road 11507 Parkedge Drive 10f. Zip Code 20721 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) filed withir Hygiene. Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Mabel Odom Ralph R. Brake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra 11507 Parkedge Drive, North Bethesda, Md. 20852 Martha Phillips-Patrick/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 6/08/2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Money & King Funeral Home, Inc. Gary R. Downer Sink Securell CCO 508 171 W. Maple Ave., Vienna, Va. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimers Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician at the burial-Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) i signed by the a d be detached for 1 ☐ Yes 2 X No Ö 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No page 2 s 1 ☐ Yes certificate ospital or Attending Physician: The hours after death.

uneral Director: After this certificate if filled in by the funeral director, par 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M D0059633 06,00,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mericantile Lane Lurgo MD يا در داد Glen 1221

State Registrar DHMH 17 Rev 1/2001

M

81 Date filed (Month, Day, Year) \_\_ . .



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 454 M Phippin, June 2013 Vaughn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICAMICO SAL 13/14/4 RIGIONAL If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) Hours 214-32-1844 Director 1 X M 2 D F 77 Maryland 06/25/1934 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked outber than "natural", or items 23a or 28a-f show uny or other traumatic event, the M. Xe. If a mining must be notifiled at ury or other traumatic event, the M. Xe. If a mining must be notifiled at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 🛛 Yes 2 🗌 No Delmar DESussex ق 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 19940 #505 U.S.A. 500 Twelfth Street, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Secondary (0-12) Custodian Education 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Delia Smith Vaughn Phippin, James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Twelfth Street, #505, Delmar, DE 19940 Eleanor Phippin / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of F Important: If ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 06/06/2012 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service Liceuse 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysiciani disease or condition y o carded Medical resulting in death) Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause this way to be a form of the cause of the caus Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi ettending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗆 No 욛 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniun work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 2412 12005061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1205 Perebutin

32. Replatrar's Signature

JARTH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav 9:15A M 2012 Putnam June Mary Frances 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Washington</u> 14121 Strite Road <u>Hagerstown</u> 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 213-42-6827 1 🗆 M 2 🕱 F Yrs. Virginia 84 04/26/1928 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No Hagerstown Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number .S.A 14121 Strite Road Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married 2 X No Yes 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Retail Bakery Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucile Thomas Muse Manuel Florence Lynton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14121 Strite Road, Hagerstown, MD 21742 Thomas M. Putnam / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 106/07/2012 | Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Signature of Funeral Servin 22. Name and Address of Facility MD 21076 Ste. P, Hanover, 7522 Connelley Dr., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death)

Physician/ Medical **Examiner** 

the burial-transit

be detached for use

page 2 s

funeral director,

certificate

within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

signed by

and

attending physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Records, P.O. Box 68760

**Division of Vital** 

Department of Health ar Important: If Item 27 is any injury or other trau

Physician/

Medical

10a. State

MD

Examiner

**Funeral** 

**Director** 

items 23a or 28a-f shov

ö

and Mental Hygiene. is marked other than "natural",

other traumatic event, the Medical

Examiner must be notified at

**Funeral Director** 

þ

Completed

Be

မ

Examiner

Physician/Medical

þ

Completed

Be

မ

Certificate:

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown

Year

24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes

25. Was case referred to medical examiner? 2 No

I ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 28d. Describe how injury occurred

5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural Accident Suicide

5 Pending Investigation Could not be

28c. Injury at work?
1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sign ure and title of certifier

determined

State

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Registrar

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20<sup>Year</sup> Flora Harrington Putnam June 1:30  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Hours Director 033-14-8099 Yrs 87 Mar 19, 1925 Massachusetts 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Montgomery Silver Spring 10e. Street and Number ō 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral 23a with 1713 White Oak Drive 20910 United States items ; hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Specify: ted 3 Widowed 4 Divorced White Comple 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Healthcare and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment, Important: If item 27 is marked any injury or act. Carl Roger Harrington Annie Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Waldo R. Putnam / Husband 1713 White Oak Dr. Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/7/2012 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of) Examiner Acute or Chronic Respiratory Insufficiency Sequentially list conditions, if any, each gits immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi Bacterimia Urinary Tract Infection Due to (or as a consequence of) resulting in death) Last physician Physician/Medical or Attending Physician; The law requires that the death certificate be Coagulopathy Division of Vital Records, P.O. Box 68760 use as ding IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death signed by the at Id be detached for Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypernatremia Completed 1 Yes 2 No 3 Probably 4 X Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1 🗌 Yes 2 🔀 No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🔀 No Other: 은 1 X Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XX Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) \*

Majid Rahmanian Shahri 1500 Forest Glen Rd. Silver Spring, MD 20910

mani Gr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D66372

29d. Date signed (Month, Day, Year,

June 4, 2012

	1 _ State		State o	f Marylan		rtment of F		and Me		- (	201	2 1823	35
	Registrar  1. Decedent's Name	e (First, Middle, i	Last)		Ceri	incate or L	Jeaur	2	2. Date of De	Reg. No.		3. Time of Dea	ath
Physician/ Medical	Jane N.	Popor	es						June June	6,	20 T2		
Examiner	4a. Facility Name (if	not institution, g	ive street and num	ber)		4b. City, Town, or	Location of	of Death		4c. (	County of De		
wax, A	11200 Ga 5. Social Security N		erve Road		11.11.6	Gait If Under 1 Year	hersb					gomery	
Funeral Director	041-22-8		1 □ M 2 🕱 F	7. Age (In yrs. la		Months Days	Hours	Min.	B. Date of Bir (Month, Da		9. E	Birthplace (State or For Country)	reign
3	Usual Residence	of Decedent	7 G W 2 24 1	83	Yrs.				July 2	4, 19	928 C	onnecticut	
yland if sho ed at	10a. State	10b. County		10c. City	, Town or Loc	ation						10d. Inside City Li	
he Maryland or 28a-f sh o notified at	MD 10e. Street and Nur	Montg	omery			Gaithers	burg					1 🔀 Yes 2	No
ith the st be	11200 Co		Dani	3		10f. Zip Code 208	70			3	en of What ited S		
leath with the items 23a cer must be	11. Marital Status	me Pres		dent Ever in U.S		as Decedent of H	ispanic Orig	gin? (Specif	y Yes or No-			nerican Indian,	
~ L.S	1 Never Marr		Armed Ford  1  Yes  If Yes, Give	2 X No		Yes, specify Cuba  Yes 2 X No		, Puerto Rio	can, etc.)		Black, Wh	nite, etc.	
21215-003 rithin 72 hours at iene. r than "natural" the Medical Ex	3 Widowed		Year or Dat									White	
72 hc 72 hc Medio	(Spe		grade completed)		(Give ki	ent's Usual Occup ind of work done of NOT use retired)		of working		16b. Kin	d of Busines	ss/Industry	
212 within giene. er the n		ondary (0-12)	College (1-	4 or 5+)		etary				Fo	od Sei	cvice	
ind 21215-0 ind 21215-0 tal Hygiene. event, the Medical o Be Complete	17. Father's Name (	First, Middle, Las	st)				18. Mothe	er's Name (F	First, Middle,	Maiden Si	urname)		
ylan uld be fi Menta narked natic ev	Arthur N						Cha	rlott	e E.	Pig	ott		
Maryland 21215-0036 2 should be filed within 72 hours after this and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by	19a. Informant's Na	,			1	Address (Street a				. ,		' '	
	Harry P		/ Husband		11200 lace of Dispos		eserv	re Roa	1			MD 20878 or Town, State	
timore, Marylar  t. Page 1 and 2 should be 1 triment of Health and Menta trant! fi tem 27 is marked jury or other traumatic e	1 🗆 Burial 2		Removal from	State C6	emetery, crem	atory or other place						, Maryland	9
Baltimore, permit. Page 1 and Department of Hea Important: If them any injury or other	21. Signature of Fu												
<b>a</b> 88 E 8 8	July	Vy FI	flerior						-		rksvi	ox 784 Lle, MD 21	029
	shock, or hear	rt failure. List onl	omplications that ca y one cause on eac	aused the death th line.	n. Do not enter	the mode of dying	g, such as	cardiac or re	espiratory an	rest,		Approximate Interval Between	
Physician/ Medical	Immediate Cause ( disease or condition resulting in death)		_ a	neimer's		se						Onset and Death	n
Examiner		-	Due to (c	or as a consequ	ence on:								
niner him	Sequentially list co if any, leading to im cause. Enter Under	nmediate	Due to (c	or as a consequ	ence of):								
xecuted n and al-transit  Examiner	Cause (Disease or that initiated events resulting in death) I	injury s	C. Due to fo	or as a consequ	ence off:								
a siar	resulting in death) i	Last	d 200 10 (c	or as a consequ	01100 017.								
3760 fficate b g physic as the t	AT TENANT		<u> </u>										
	IF FEMALE: 23b. Was decedent in the past 12 a		23c. If yes, outc	ome of pregnar	ncy Ideath 3 🗆	Ectopic pregnanc	v			2:	3d. Date of o	delivery	
O. Box 687, the death certificated by the attending pletached for use as the physician/Me	1 Yes 2 S	₹ No	4 ☐ Pregn g ☐ Unkno	ant at time of d	eath 5 🗌	Other (specify)					Month	Day Year	
P.O. that the ned by the detacl	Part II. Other signif		s contributing to de	ath but not resu	ulting in the un	derlying cause giv	en in Part I		23e. Did to	obacco us	e contribute	to the cause of death	?
Records, P.O. Box 687  The law requires that the death certifica cate has been signed by the attending playage 2 should be detached for use as to completed by Physician/Me	Atheroso	clerotic	Peripher	al Vaso	cular D	isease			1 🕱	Yes 2	No 3 □	Probably 4 🗆 Unkr	nown
Division of Vital Records, all or Attending Physician: The law requires as after cleath.  In Director: After this certificate has been signed in by the funeral director, page 2 should be Certificate: To Be Completed by	Atheroso	clerotic	Heart Di	isease					24a. Was		24b. Were	autopsy findings availa	able
Reco									autor perfo 1  Yes	rmed?	death'	o completion of cause ? ⁄es 2 ☐ No	3 01
cian: ertific ector,	25. Was case referre examiner?		Hospital:					h (Check or					- 3
Physi this or ral din	1 Yes 2 2 27. Manner of Death		1 🗆 1	npatient 2 1	ER/Outpatient 28b. Time of		4 ∟ Nu		5 X Resid			ecify)	
ivision of or Attending P after death. Director: After t I in by the funers Certificate:	1 X Natural 2 Accident	5 Pending		of injury n, Day, Year)	injury	28c, Injury work M 1			d. Describe h	now injury (	occurred		
isio Atter ectora by the	3 Suicide 4 Homicide	6 Could no	t be 28e. Place of	of Injury - At hor	me, farm, stree	et, factory, office					Number or F	Rural Route Number,	
Div ital or ital or al Dir illed in			buildin	g, etc. (Specify)				4	City or Tow	vn, State)			- 4
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for Medical Certificate: To Be Completed by Physicia	(Check 2	■ Medical Exa	hysician: To the be aminer: On the basis arse Practitioner:	s of examination	and/or investig	ation, in my opinio	n, death oc	curred at the	e time, date a	and place, a	and due to th	e cause(s) and manner	stated.
To th within	29b. Signature and		1/10			29c. License				· ·		nth, Day, Year)	
		Mill	41	lell 1	SHO		35404			Ju	me 6,	2012	
7	30. Name and add Michael		o completed adse 15005 Sha		/ 1 / /	,	le, M	ID 208	550				
State Registrar	31. Date filed (Monti	b. Day, Year)	22	istrar's Signati	Iro -								
X DHMH 17 Rev 06-2011		IUN 0 8	UIZ COR	wa p	i. jajuan								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:20 A M Jeanne Perkins May 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) Director 187-20-6684 1 M 2 XF 86 Nov 19, 1925 Oklahoma 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Columbia Howard 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6336 Cedar Lane #175 21044 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or ģ 1 Never Married 2 Married Yes 2 No Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Specify. 3X Widowed 4 □ Divorced Completed White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) should be filed within and Mental Hygiene. 4 Executive Assistant Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Forrest Fred Versaw Medley Ruth Jewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other tra. Kevin L. Perkins / Son 11048 Gaither Farm Rd. Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/9/2012 Woodbine, Maryland 21. Sign / e of Funeral Service Lic Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Weeks neumonia Medical resulting in death) to (or as a consequence of): **Examiner** niemers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical that the death certificate be P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ō in the past 12 months? Month Day Year signed by the at Id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been signated by the state of t Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 perform death? 24 hours after death.
Funeral Director: After this certificate hetely filled in by the funeral director, pag Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical within 24 hou

To the Fune

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 06-2011

State

Registrar

BINDL

CEDAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

336

D0060634

ANE

COLUMBIA

5128112

12-0	4082

urdes Fernan		o tate of that yarra / Boparti		Health an Death	d Mental H		2 U Reg. No.	12 1823
Physici edical Exami		Decedent's Name (First, Middle, Last)     Lourdes Fernandez Petr				2. Date of Dea Month	ath Day Year	3. Time of Death 2045 hrs
> Cicai Lxaiii	iner	4a. Facility Name (if not institution, give street and number)	4	4b. City, Town, or	Location of Deatl	May 29, 2	4c. County of	
je je		2300 Ravenview Road		Timonium			Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year Months Day		ī. T	F	9. Birthplace (State or oreign Dominican
Director		Unknown 1 M 2 X F Usual Residence of Decedent	82 Yrs.			11/06	/1929	country, Republic
, any		10a. State 10b. County 10c. City, Tow	n or Locati	on			······································	10d. Inside City Limits
land f show	tor	Maryland Baltimore Timoni	ium					1 Yes 2 X No
the Mary ta or 28a stiffed at	Director	10e. Street and Number 2300 Ravenview Road		10f. Zip Code 21093			10g. Citizen of What USA	: Country?
r death with the Maryland or items 23a or 28a-f show must he notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married   12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No	If Ye	es, specify Cubar	spanic Origin? ( S n, Mexican, Puerto	Rican, etc.)	White, e	_
s after ral", o	by	3 Widowed 4 Divorced If Yes, Give Yaar or Dates:			specify: Dom		ореспу.	hite
imore, MD 21215-0036 Pages I and 2 should be filed with 72 hours after death with the Maryland ment of Heatht and Mental Hygien was the fire 27 is marked other than "natural", or items 23a or 28a-f abo or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo		tion (Give kind of . DO NOT use ret Stant		Maryland Surgry a Medicine	Plastic nd Family
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than numatic event, the Medica		17. Father's Name (First, Middle, Last)		I		•	Maiden Surname)	
212 uld be i Mental marke	To Be	Tulio Fernandez Almanar  19a. Informant's Name/Relationship (Type, Print)  11	9b. Mailing	Address (Stree			Pichardo	
MD 12 sho th and 27 is umatic		Diogenes Fernandez Sanchez brother						outin, Esp outin,
		1 Burial 2 Cremation 3 Removal from State crema	atory or oth		**	Date	20c. Location - C	
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify:		natory,I	- 1		1	e,Maryland
Ball permit Depar Impo		21 Signature of Funeral Service Licensee Stephanie Custer	299	9 Freder	ick Road	Baltim		and 21228
Physician //Medical		23a. Part I. Enter the disease, or complications that caused the death. Do rfailure. List only one cause on each line.			such as cardiac o	or respiratory an	rest, shock, or heart	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovasc Due to (or as a consequence of):	ular Dise	ease				Death
		Sequentially list conditions, b						
	Examiner	if any, leading to immediate  The Find Indexpine Count  (Disease or injury that initiated						
ecuted and transit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.						
ial ial	edical	UNPENDED AMENDED						
3760 ficate l g physis the bu	ΣI	IF FEMALE: 23b. Was decedent pregnant in the		al death 3	Ectopic pregna	20.004	23d. Date of de Month	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but	sicial	past 12 months?  4 Pregnant at time of death		aldeath 3   ner <i>(Specify)</i> _		aricy	World	Day Year
b, Bc the dea by the a	Physici	Part II. Other significant conditions contributing to death but not resulting	na in the u	nderlying cause (	siven in Part I	23e Did t	obacco use contribu	te to the cause of death?
of Vital Records, P.O. Eing Physician: The law requires that the dAfer this certificate has been signed by the uneral director, page 2 should be detached	Ď			indonying addoor	giron in i dici.			Probably 4 🗹 Unknown
rds,	Completed					24a. Was		re autopsy findings available or to completion of cause of
He law ate has age 2 s	E O				<del></del>		rmed? dea	
tal Risin: 1	BeC	25. Was case referred to medical examiner?		26.Place	of Death (Check			
Division of Vital Records, ral or Attending Physician: The law requires after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should be	၉	1 Yes 2 No No Inpatient 2 ER/C	Outpatient Time of Ir		Other Nursir		Residence 6 🗸	Other: Scene
on of vending Phath.  or: After the funeral	Certification:	1 V Natural 5 Pending (Month, Day, Year)			res 2 No	zou. Decombe	now injury occurred	
Division pital or Attencours after death neral Director:	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, stree	t, factory, office b	ouilding, etc.	28f. Location ( or Town, S		or Rural Route Number, City
Division or A hours after Ineral Dire	Ser	4 Homicide determined (Specify)  29a. Certifier				or rown, s	otate)	
是 2 是 B		(Check only 1 Certifying Physician: To the best of my knowledge, de						
o the ithin o the omple	dical	one) 2 Medical Examiner. On the basis of examination and/or				,	,,	to the cause(s)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(2.1.2.1)		29c. Licens	e number		29d. Date signed	(Month, Day, Year)
To the within To the To the comple	Medical	ore) 2 Medical Examiner. On the basis of examination and/or and manner stated.  29b. Signature and title of certifier  Policy			e number			(Month, Day, Year)
To the within To the comple	Medical	one) 2 Medical Examiner; On the basis of examination and/or and manner stated.		29c. Licens	e number		29d. Date signed May 30, 2012	(Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

ichael Edward	Pitt	man 1- For State Registrar	State	of Maryland		rtment of <i>tificate of</i>		nd Mental I	Hygiene	Reg. No.	201	2 1823
Physici			e (First, Middle,Las	st)					2. Date of D		Year	3. Time of Death
ledical Exami	ner		L EDWARD						May 30,	2012		0932 hrs
)		9715 Euclid	Street	e street and number	")	ĺ	Cheverly	or Location of Dea		Pi	County of Dea rince Georg	je's
Funeral Director		5. Social Security N	12	9X 7. A	ge (In yrs. Ia	st birthday) Yrs.	Months Da		in	3irth(MM/D -1957	Fore	irthplace (State or ign MEMPHIS ountry) TENNESSEF
any		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Locati	on		-			10d. Inside City Limits
<b>*</b>	7	MD	PRINCE O	GEORGES		CHEVERI	LY					1 Yes 2 No
Aaryla 28a-f	Director	10e. Street and Nur	mber				10f. Zip Code			10g. Citiz	en of What Co	untry?
h the l 23a or			EUCLID ST	<del></del>			2078				USA	
215-0036 ntable figure after death with the Maryland ntable figure with 12 hours after death with the Maryland read other than "natural", or items 23a or 28a-f abe out, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Marrie	ed 2 Married	12. Was Deceden Armed Forces 1 Yes 2		5. 13. Was	s Decedent of Hi es, specify Cuba	ispanic Origin? ( : n, Mexican, Puer	Specify Yes or It to Rican, etc.)	No- 1	14. Race - Ame White, etc.	rican Indian, Black,
s after ral", o	by F	3 X Widowed		If Yes, Give Year or Dates:			Yes 2 X No				Specify:	WHITE
2 hour "natu	ted	15. Decedent's Ed		nly highest grade cor College (1-4 or				ation (Give kind of e. DO NOT use re		16b. Ki	ind of Business	/Industry
21215-0036 Muld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Completed	12T	H		,	UTILIT	TY WORKE				LIC UT	LITIES
21215-003 ould be filed within i Mental Hygiene. s marked other the ic event, the Medi		17. Father's Name (						18.Mother's Nam			,	_
Z 골 등 를 입	ro Be	DON PITTI 19a. Informant's Na		ype, Print )		19b. Mailing	Address (Stre	et and Number or	Rural Route N			e, Zip Code)
AD 2 sho 2 sho 27 is		PAUL LEM	IEUX III		1	1	7 DUDALA		OUDON, !			
2 5 E		20a. Method of Disp		Removal from St		lace of Disposi rematory or oth	tion (Name of ce er place)	emetery,	Date 5-5-201	20c. Lo	ocation - City o	r Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		4 Donation 5	Other Specify	:				GARDENS				TENNESSEE
Balt permit Depart Impor injury		21. Signature of Fu	neral Service Licer	isee		22. N		s of FaCHAR				
Physician	_	23a. Part I. Enter th	e disease, or comp	lications that caused	the death.	Do not enter th		, such as cardiac			O.MD. 2 k, or heart	Approximate Interval
/Medical		failure. List onl Immediate Cause (I	y one cause on ea	ach line. <b>Atherosc1</b>	ereti	e Cardi	owaecu1	or Diego				Between Onset and Death
Examiner		or condition resulting		Due to (or as a cons			DYGGCGI	ar proce	oc.			
	ē	Sequentially list cor if any, leading to im	mediate	Due to (or as a cons	equence of)	:						1
	Examiner	eause. Enter Unde (Disease or injury th	nat initiated C.	Due to (or as a cons	aguanca of)							9
executed an and al - transit		events resulting in o	d.	•								
O, e be exe sician a	edical	X UNPENDED		AMENDED 23a	,27,p	er me,g	928 6-1	2-12 sm				
68760, certificate be nding physici		IF FEMALE: 23b. Was decedent i		23c. If yes, outcom	me of pregn		al death 3	Ectopic pregr	ancy		Date of deliver	y Day Year
X = 2 ?	Physician/N	past 12 months		4 Pregnant at	time of dea	=	er (Specify)		ica icy	1 "	NOTHIT	Day Teal
g the g	hys	1 Yes 2 N		9 Unknown	b bud = 44 co.			airea ia Dad I	Dan Did	tabassa	an anatributa ta	the cause of death?
F. P. O. ires that the signed by I be detach	ģ	Part II. Other eight	tant conditions	contributing to deat	ii but not res	suiting in the di	idenying cause	giveri in Fait i.			_	bably 4 V Unknown
ords, w require s been si should b	eted								24a. Wa			utopsy findings available
of Vital Records Ing Physician: The law requi After this certificate has been uneral director, page 2 should	Completed			·					perf	opsy ormed? 2 No	prior to death?	completion of cause of es 2 No
III. The strifficator, pa	Be Co	25. Was case refer	ed to medical	<del> </del>			26.Place	e of Death (Check		2110		es Z NO
Vital   hysician: this certifi d director,	TO B		2 No	lospital: 1 Inpatie	ent 2 🔲 i	ER/Outpatient	3 DOA	Other Nursi	ing Home 5	Residen	ce 6 🗸 Othe	r; Scene
C #	Ë	27. Manner of Death  1 X Natural		28a. Date of Inju (Month, Day,)	ury (ear)	28b. Time of In		ry at Work?	28d. Describe	how injury	y occurred	
Sion Atten r death ector: by the	cati	2 Accident	Investigati	28a Place of Ir	niurov - At hor	ne farm street	t, factory, office t	Yes 2 No	28f Location	(Street and	d Number or P	ural Route Number, City
Division At spital or At tours after defined in by filled in by	Certification:	3 Suicide 4 Homicide	6 Could not determined	De	,,, , , , , , , , , , , , , , , , ,		, radiory, difficult	ourumg, oto.	or Town,		a Hamber of Re	arai reduce Hamber, Ony
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical			an: To the best of m On the basis of exa and manner stated.								
	Σ	29b. Signature and	title of certifier				29c. Licens				•	nth, Day, Year)
		00 No. ///	10			N)	O.C.	IVI. ⊏.		May 3	31, 2012	
		30. Name/and address Russell Alex		completed cause of c Assistant Medic	. /		V. Baltimore	Street, Baltir	more, MD 2	1223		
	ate	31. Date filed (Monti	h, Day, Year) 1082012	2. Registra	ar's Signatur	back	1					<u>-</u>
Regist	_	JUN	V 0 2012	OCME	14.	OPIONA		-				

ORIGINAL

Tammy A. Ramage	1	- For State	Sta	ite c	of Maryla	and / C	Depart <i>Certit</i>	ment o ficate d	of Hea of Dea	alth an a <i>th</i>	id Men	tal Hyg		Reg. No	20	12	1823
Physician		egistrar I. Decedent's Nam										2.	Date of De Month		Year	13	3. Time of Death 2023 hrs
Medical Examine			A. Rama			1 = 3			4h Cit	Tours or	r Location o		June 2, 2	2012	c. County of	Death	2023 HIS
	ľ	ta. Facility Name ( St. Agnes h		, give	street and nu	imber)				timore	Location						
Funeral Director		5. Social Security		6. Sex		7. Age (1	n yrs. last		Mo	nder 1 Yea	_	_			ı	Foreign	place (State or
Director		215-80 - Usual Residence of		1!	M 2 XF			52 Y	rs.				07/2	1/19	959		ntry) Maryland
any	_	10a. State	10b. County			10	c. City, To	own or Loc	ation					-		- 1	10d. Inside City Limits 1 X Yes 2 No
f show	5	MD					Ba1	timor		ity Zip Code			_	10a Ci	tizen of Wha		
the Maryland o or 28a-f sh		10e. Street and Nu 3304 E	nglish	Cor	rsul Av	ze.			101.	2123	0			_	SA	Coount	.,
r death with the Maryland or items 23a or 28a-f show must be notified at ooce.		11. Marital Status			12. Was Dec	edent Ev	er in U.S.			edent of Hi			cify Yes or N	No-	14. Race - White,		an Indian, Black,
r death with or items 23		1 Never Marr		rried	1 Yes	2 🔁	No	"	_ `	_	specify:				Specify: W		e
rs after ural", miner	╗┞	3 Widowed  15. Decedent's E			If Yes, Give Yea or Dates: y highest grad		eted) 1		ent's Us	ual Occupa	ation (Give	kind of wo		16b.	Kind of Busi		
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exau	5 -	Elementary/Sec		Ť	College (1			-		_	e. DO NOT	use retired	4)		O II -		
vithin iene.		11						Home	emak	er	19 Mothor	r's Name (F	iret Middle		Own Ho	me —	
215-( be filed on the high of the oth the cot, the Back of the Bac	5	17. Father's Name Robert	Claude		itzgera	a1d							Mari				
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Important: If item 32a or 28a-f sho injury or other traumatic evect, the Medical Examiner must be notified at socca-		19a. Informant's N Debora	lame/Relations h Johns			hter									City or Town,		
e, M and 2 Health:	ŀ	20a. Method of Dis	sposition					ce of Disp		Name of ce	emetery,		Date	200	. Location - 0	City or T	fown, State
MOFO Pages 1 ent of 1 nt: If	1	1 Burial 2 4 Donation 5			Removal fr	rom State		wnsv	ille	Vet			7/12		rownsv		
caltin	İ	21. Signatur			ee			22	. Name a	and Addres	ss of Facilit	y Ambi	cose 1	une	ral of	La	nslowne D 21227
	4	23a. Part I. Enter	the disease, or	compli	cations that o	aused the	e death. D										Approximate Interval
Physician /Medical.	Į	failure. List of	nly one cause	on eac	ch line. <b>Alcoho</b>											g/	Between Onset and Death
Examiner		Immediate Cause or condition result			ue to (or as a				C (110	I pital	10/11						
		Sequentially list of if any, leading to it cause. Enter Unit	mmediate	b.	Oue to (or as a	a consequ	uence of):										
ed nsit	Exam	(Disease or injury events resulting in	that initiated		Due to (or as a	a consequ	uence of):							_			
0, the executed sician and purial - transit	G Cal	X UNPENDE	D	d. <u> </u>	AMENDED	23a,	27,28	a-f,	per	me,g9	28 6-	-13-1	2 sm				
68760 certificate I nding phys	šΓ	IF FEMALE: 23b. Was deceden		е	23c. If yes,		of pregna	_	Fetal de	ath 3	Ectop	ic pregnan	су	2	3d. Date of o Month		ay Year
Sox 6876C leath certificate e attending phys for use as the b	200	past 12 month	ns? No9✔ Unl	nown			ne of deat	h 5	Other (	Specify)							
<b>ய</b>	Pnysici	Part II. Other sign			9 Unkn		out not res	ulting in th	e underl	ying cause	given in P	art I.	23e. Dio	d tobacc	co use contrib	oute to t	he cause of death?
ires that signed to be deta	a												1 🗆 ነ	res 2	No 3	Prob	ably 4 🗹 Unknown
of Vital Records, P.O. og Physiciae: The law requires that th when this certificate has been signed by meral director, page 2 should be detach	Completed													topsy	pr	rior to co	opsy findings available ompletion of cause of
(ecol													1 ✔ Ye	rformed s 2		eath? ✔ Ye	s 2 No
Vital Rec bysiciae: The I this certificate I director, page	80	25. Was case refe examiner?	erred to medica		ospital:		_ [			_	Other		-		e [	Other	
f Vir Physic er this	의	1 Yes  27. Manner of De	2 No		28a. Date	Inpatient of Injury	- 12	R/Outpati 28b. Time		DOA 28c. Inj	jury at Wor		Home 5 28d. Describ		njury occurre		·
On of \ coding Phy ath. r: After the funeral		1 Natural	5 Pend		E4 6	h, Day,Yea <b>-2-1</b>	1	fd 200	00 hr	.s 1	Yes 2	No 1	ınknov	m			
Division tal or Atteodic rs after death. al Director: A	Certification:	2 Accident 3 Suicide	6 X Cou		28e. Pla						building, e		or Town	n, State)	3304 E	ngL	ral Route Number, City <b>ish Counsul</b>
Spital spital hours a ocral / filled		4 Homicide		rmined	(apera)		1 ro				4.4 4 .	_	ve. B	alt:	imore,	MD.	
Division To the Hospital or Atteod within 24 hours after death. To the Froeral Director: completely filled in by the	edical	(Check only 1 one) 2	=	nysici: miner	an: To the be On the basis	of exami	nation and	e, death od d/or invest	curred a igation, i	t the time, n my opinic	on, death o	occurred at	the time, da	ate and	place, and du	ue to the	e cause(s)
5 % it is	ĕ	29b. Signature an	nd title of certific	er	and manner	stated.	0/	Λ		29c. Licer	nse numbe	r		29	d. Date signe	d (Mor	nth, Day, Year)
		30. Name and ad	Cu		M	1	off (ltom 2	) (		0.0	C.M.E.			Ju	une 3, 201	2	
		30. Name and ad			stant Medi				. Baltir	more Sti	reet, Bal	timore, l	MD 2122	3			
Sta		31. Date filed (Mo	onth, Day, Year)		32. R	Registrar's	Signature	e									
Registr		- JUI	<del>1 n à 5</del> 0	12	JOHN	-	13.	200	MAI			_					
DHMH 17 Rev 1/200	J1							ORIGII	AVE								Le - 1018m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Strug-t osalir Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner (to: n= (== ( 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. (Month, Day, Year) 217-18-1043 Director 1 M 2 F 90 6 aryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be nottliked at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Nes 2 No Hima 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral XINGTON 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No and Mental Hyglene. 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည ON am 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21163 Woodstock 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Depertment of H Important: If ite any injury or otl cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4/2012 Baltimore, 4 Donation 5 Other (Specify) 22 Name and Address of Fesility 21. Signature of Funeral Service Licenses Funeral Home, P. A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician end s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as 1 attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autonsv 1 Yes 2 No Yes To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JUN 0 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Leonora Settersten <sup>Day</sup> 2012 2:52 РМ June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 8302 Jeb Stuart Road Montgomery Potomac Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours Min Jan. 14, 1931 1 M 2X F 371-30-7019 81 Michigan Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 8302 Jeb Stuart Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 🔀 No þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: "natura!", Completed 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dental Dental Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Oleneack Helen Czerwinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Thomas B. Settersten/Son 105 Monasterio Court, San Ramon, California 94583 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Souls Cemetery 20a. Method of Disposition June 11, 2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Germantown, Maryland I Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc 21. Signature M00198 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin Hyperlipidemia requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular Accident 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown has been signed by the second 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law autopsy performed page certificate 2 No 2 X No 1 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 No Other: 1 X Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R129771 June 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CRNP

32. Registrar's

Pamela Godwin,

5530 Wisconsin Avenue #530, Chevy Chase, Maryland

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fh 9928 6-8-12 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0442M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yelar) **Funeral** 9. Birthplace (State or Foreign Days Months 96 -50 1 M 2 D F Director Mary laund 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director ANNE 1 Yes 2 No Hanover 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 750 2 MANN 076 ILS.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 1 and 2 should ba filed within 72 hours aft f Haaith and Mantal Hygiane. Item 27 Is marked other than "natural", If Yes, Give 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 20H Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) မ 10 19a. Informant's Name/Relationship (Typ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Injury or othar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dapartment of the Important: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) tanovar 21. Signature of Funeral Service Ligensee uveral 22. Name and Address of Facility +OME 10220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ad by tha attanding physician and datached for usa as tha burlal-transit Hospital or Attending Physician: The law requires that the death certificate be exacuted that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Records, P.O. To the Hospital or Attentions within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the completely filled in by the funeral director, page 2 should be detacted. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? ပ္ 2 🗌 No Other: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 D No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month/Day, Year) PUT of death (Item 23a) (Type, Print) Ne5 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Mollye Shulman A M Medical 6 2012 6:57 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Eden Homes Group Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth Months (Month, Day, Year) Director 079-18-7595 1 M 2 X F 88 6-28-1923 New York Usual Residence of Dece ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6505 Stoneham Road 20817 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. natural", or ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 XWidowed 4 □ Divorced Completed Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Oscar Gross Fannie Schoenfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Fred Shulman - Son 10 Flints Grove Dr. N. Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State nent of 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington Nat'l Cem. 6-4-2012 Arlington, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licens any in Brian Deibler Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dysphagia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dementia, Lewy Body Type Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 No Assisted Living 1 ☐ Yes 2 💢 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Investigation 2 🗌 No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 06/01/2012 D35579

Registrar

DHMH 17 Rev 06-2011

State

MD - 8218 Wisconsin Avenue, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Miller,

<u>JUN 0-8-2012</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-04233 State of Maryland / Department of Health and Mental Hygiene Michael Joseph Sullivan Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ June 4, 2012 1059 hrs Medical Examiner MICHAEL JOSEPH SULLIVAN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 5514 Belair Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min Country MARYLAND Director 10-28-1956 55 220-62-1767 1 AM 2 F Vrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No BEL AIR HARFORD MD. 28a-f show t. Pages I and 2 should be filed within 72 hours after death with the Maryland functiof Health and Mental Hygiene. notified at once rector 10g, Citizen of What Country 10f. Zip Code 10e. Street and Number **USA** 21015 CRESWELL ROAD 2114 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? 1 X Never Married Yes WHITE Yes 2 X No specify: Specify. If Yes, Give Year 3 Widowed 4 Divorced ۾ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) SULLY'S SEAFOOD OWNER 12TH Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARGARET L. HOCK JOSEPH J. SULLIVAN JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2104 162 ST. EAST BRADENTON, FL. 34211 MARGARET ISAAC MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State or other GLEN BURNIE, MD. ATLANTIC CREMATORY 6-9-2012 4 Donation 5 Other Specify: 22. Name and Address of Facility MILLER=DIPPEL FUNERAL HOME, INC, Sign ture LFuneral Service Licensee 6415 BELAIR ROAD BALTO.MD. 21206 23a. Rart I. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Retween Onset and Death Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exa pur Physician/Medical ittending physician or use as the burial -UNPENDED AMENDED the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day 1 Live birth Fetal death has been signed by the attending 2 should be detached for use as 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No certificate director, page 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Subject shot FOUND: Natural 1 ✓ Yes 2 No Pending Director: d in by the hours after death Jun 4, 2012 1045 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 5514 Bel Air Road, Baltimore , MD determined (Specify) Convenience Store To the Funeral 4 Momicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 5, 2012 O.C.M.E.

( ) State

31. Date filed (Month, Day, Year)

32. Pgistrer's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OGME

Laron Locke MD.

Registrar

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 2012 June 5:55 A M Heath Shaw Barbara Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Adamstown 3200 Baker Circle #I-013 Birthplace (State or Foreign Country) Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 229-28-656 **Director** 1 🗆 M 2 💢 F Washington DC Aug 28, 1928 83 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 XNo Frederick Adamstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò r items 23a or iner must be r Funeral 21710 United States 3200 Baker Circle #I-013 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status and Mental Hygiene.
Is marked other than "natural", or iter Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Gertrude Cavan Raymond William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a 3200 Baker Circle #I-013 Adamstown, MD 21710 Department of Health Important: If item 2: any injury or other t Benjamin A. Shaw / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Woodbine, Maryland Final Journey Crematory 6/7/2012 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Sen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Phag disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending property for use as IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 menths?
1 Yes 2 No 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes Division of Vital Records, is certificate has been si director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 Yes 2 No this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After Natural 5 Pending injury 24 hours after death. Funeral Director: Al 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature ar title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

65C

Thonson

redences

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hiren filed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 5:15PM Stracke Gregory Tune 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Hnne Nedical Cen Ou Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreig Country) **Funeral** Months 213-26-6684 **Director** 1 🗓 M 2 □ F 83 01/13/1929 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No Ferndale MD Anne Arundel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral U.S.A. 21061 109 Cromwell Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 No by 1 Never Married 2 Married 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 ☐XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Printing Printer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important. If item 27 is marked any injury or other traumatic once. ည Milwicz Mary Stracke Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD Mrs. Denise Roeder / Daughter 301 Maro Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 06/09/2012 Brooklyn Park, MD Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD 21. Signature of Funeral Service License MO1479 Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COLON CANCETL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform 2 - No this certificate 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at within 24 hours after death. To the Funeral Director; After work?
1 Yes 2 No injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertilying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso Acimoun Year, 32. Registrar's Signature State IUN 0 8 2012 Registrar

				Please	Type or Prin								egible.	
			For State		State of Ma	aryland		artment of F			-	- 9	012	18247
			Registrar	(First Stindelle Lee			Ce	ertificate of	Deali		2. Date of De	Reg. No. 🛴	.016	3. Time of Death
	Physici		Decedent's Name     DEATED TOE	(First, Middle, Las	i.i.			CHARTRO			Month	Day	Year 2012	A
	/Medic	_	BEATRICE 4a. Facility Name (If	not institution, give	street and number)			SHAPIRO 4b. City, Town, o	r Location		JUNE	4c. Co	ounty of Death	
1	Examin	er	, ,	E HEBREW				BALTIM				N	/A	
	Funeral		5. Social Security Nu	mber 6. S	ex 7. Age	e (In yrs. la	st birthday				8. Date of Bir (Month, Da	th	9. Birth	nplace (State or Foreign intry)
	Director		052-18-29	966	□м 2ДТ	88	3 Yrs.				01/06	/1924		NY
	and w		Usual Residence of I 10a. State	Decedent 10b. County		10c. City,	Town or L	ocation						10d. Inside City Limits
	Maryl f sho	호	MD	BALTIM	ORE	OW	TNGS	MILLS						1 □Yes 2 No
	r 28a	irec	10e. Street and Num					10f. Zip Code				10g. Citize	n of What Cou	untry?
	th with	Funeral Director	4730 AT	RIUM COU	RT, #525			21117				USA		
	ems er m	ner	11. Marital Status	**	12. Was Decedent Armed Forces?		3. 13	. Was Decedent of H If Yes, specify Cub	lispanic O an, Mexica	origin? (Spe an, Puerto I	cify Yes or No Rican, etc.)	. 14	<ul> <li>Race - Amer</li> <li>Black, White</li> </ul>	
36	s afte		1 ☐ Never Marrie		1 ☐ Yes 2 ☒ I If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🖾 No	Specify	y:		S	pecify: WHI	<b>т</b> ғ
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by		15. Decedent's Ec			16a. Dec	edent's Usual Occup	ation			16b. Kind	of Business/I	
75	in 72 In "na Medic	plet	(Speci	fy only highest gra	de completed) College (1-4or 5	i+)	(Giv life.	e kind of work done DO NOT use retire	during ma d)	ost of workir	ng			
	filed with Hygiene other that snt, the	E O			5+			TEAC				L		CATION
pu	be file	a	17. Father's Name (	First, Middle, Last)			, DIIMA	**			(First, Middle	, Maiden Si		EOMEN
yla	should be ind Mental marked c	5	ISIDORE  19a. Informant's Na		Tuno Brint)		DEUTC	H iling Address (Street		ARAH	I Route Numb	ner City or T		ESTEN
Maryland	C1 60 00 00				RO/HUSBAND			,				-		MD 21117
	s 1 and f Health item 27 other tr		20a. Method of Disp	osition		20b. Pl	ace of Dis	position (Name of rematory or other pla	i		ate		ation - City or	
Baltimore,	Pages nent of I int: If its iry or o			Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State  y)			ND VETERA		06/07	/2012	OW	INGS M	ILLS, MD
alti	permit. Page Department of Important: If any Injury of once.	Ιï	21. Signature of Fun	neral Service Licer	isee [ III			22. Name and Addre	ss of Faci	ility SOL	LEVINS	SON &	BROS.,	INC.
<u> </u>	<b>8 3 2 6 5</b>		AG	MM.	utter		109						SVILLE	, MD 21208
			23a. Part1. Enter the shock, or hear	e disease, or com t failure. List only	plications that caused one cause on each li	the death ne.	. Do not e	nter the mode of dyi	ng, such a	as cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
A	Physician		Immediate Cause (I disease or condition resulting in death)	Final		1EN		-						YEARS_
1	/Medical Examiner	ш	,		Due to (or as	a consequ	ence of):							
		ē	Sequentially list cor if any, leading to im	nditions, mediate	b. Due to (or as	a consequ	ence of):							
	od dansit	Examine	cause. Enter Under Cause (Disease or i that initiated events	njury	C								- 5	
o,	be executed ician and burial-transit	EX	resulting in death) L	ast	Due to (or as	a consequ	ence of):							
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	Jical			d									
9 ×	death certificate e attending phys	Physician/Medica	IF FEMALE:		23c. If yes, outcome	of pregna	nev					00	Bd. Date of del	ivon
Bo	eath c attend for us	cian	23b. Was decedent in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	B Ectopic pregnand	y			23	Month	Day Year
P.O.	0 0 D	ysi	1 □ Yes 2.2 9 □ Unknown	No	9□Unknown									
	requires that the een signed by th hould be detache	by Pt			contributing to death b	ut not resu	ilting in the	underlying cause gi	ven in Par	rt I.	23e. Did	tobacco use	e contribute to	the cause of death?
Records,	w requires to been signed should be of		_OSTE	=O PORC	DSIS					—.	1 🗆	Yes 🗡	No 3□Pr	robably 4 Unknown
ecc	law as b	Completed	LEFT	HIP 1	= RACTURE	SE	COND	ARY TO	OSTEC	POROS		psy	prior to	utopsy findings available completion of cause of
E	The ate h page	Com									peri 1∐ Yes	ormed? 2 No	death? 1 ☐ Yes	2 □ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referrexaminer?		Hospital:			_ Ot	her:	_	(Check only			
ō	Phys this ral dir	-T	1 ☐ Yes 2 ☐ 27. Manner of Death		1 ☐ Inpati		ER/Outpati 28b. Time	ient 3 DOA	4)25		me 5∐ Res 28d. Describe		Other (Spe	cify)
Division	Attending F r death. ector: After by the funer	tion	Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	ay Year)	Injun	·	rk? ]Yes 2[	□No				
Visi	or Attend after death Director: , in by the f	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		jury - At ho	me, farm,	street, factory, office				(Street and own, State)	Number or R	ural Route Number,
Ö	s afte al Dir	Certification:	4 LI Iomidia	_	J Dullaring, e	tc. (Opecii)	′′				Ony or 11	, Otato)		
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by		29a. Certifier (Check only	1 ➤ Certifying PI 2 ☐ Medical Exa	nysician: To the best miner: On the basis	of examina	wledge, de tion and/or	eath occurred at the investigation, in my	ime, date opinion, d	and place, death occur	and due to the	e cause(s) a e, date and	and manner as place, and due	s stated. e to the cause(s)
	the thin 24 the fundamental th	Medical	one) 29b. Signature and	title of certifier	and manner s	tated.		29c. Licer	se numbe	er		29d. Date	signed (Moni	th. Day, Year)
	Witi To		230. Signature and	spi certiner	MP							_		
			30. Name and addr	ess of person who	completed cause of	death (Item	1 23a) (Tvn		9 d	895		JUN	c, c	6,2012
			PAULIN	^										
		ate	31. Date filed (Mon	th, Day, Year)	2. Regist	rar's Signa	ture	e del						
	Regist	rar	70	NO 8 2013	Bren	1 p	194	not the same of th						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 40 PM June 2012 Louis Henry Scheeler 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Ellicott City Shangri La Assisted Living Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours 213-10-8205 92 **Director** 1XXM 2 □ F Oct.10,1919 MD Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tiffer 275 marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2XXNo 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21060 108 Ralph Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1XXYes 2 □ No Black, White, etþ 1 Never Married 2 Married 1XXYes If Yes, Give White altimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify Completed 3 ₩Vidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Government Ò Manager 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Henry Scheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3164 Ryerson Circle Halethorpe, MD 21227 Paul Roach / Brother-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or Baltimore, MD Loudon Park Cemetery 6/7/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Deal Year Immediate Cause (Final Physician/ disease or condition resulting in death) Vascular Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the b IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ fo in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 2 No 3 □ Probably 4 □ Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? performed? 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6XXOther (Specify) Living  $\cong$ 2XXNo Hospital: 1 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27, Manner of Deatl 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1xxNatural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospi within 24 hou To the Funer completely fil

State Registrar (Check

only one

29b. Signature and title of certifier

Harry Li, MD 8600 Snowden River Parkway, #301 Columbia, MD 21045 JUN 0 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

June 6, 2012

Certifying Nurse Plactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D56531

12-04154 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.								
Calvin Jerome Taylor State of Maryland / Department of Health and Mental Hygiene								
1- For State Certificate of Death Reg. No.								
Physicia		1. Decedent's Name (First, Middle,Last)	Date of Death     Month	h Day Year	3. Time of Death			
Medical Exami	ner	Calvin Jerome laylor	June 1, 20	12	1256 hrs			
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat	h	4c. County of Deat	n			
		208 N. Aisquith Street Baltimore						
Funeral				h(MM/DD/YYYY 9. Bi				
Director	- 1	213-12-9512 1 M 2 F 51 Yrs. Months Days Hours Mir	4/4/		ountry) M b			
		Usual Residence of Decedent	11141	1.1011				
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
ibow Ge.	<u>_</u>	MX NA Paltimore			1 Yes 2 No			
death with the Maryland or items 23a or 28a-f show must be notified at once.	<b>Funeral Director</b>	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?			
he M	ä	200 Airanda Street 21202		110	Δ			
s 23s	펺	11. Magital Status / 1.2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	ican Indian, Black,			
eath y	2	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
iter d		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 ✓ No specify:		Specify: P	lack			
urs ad	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business/	Industry			
12 ho	ete.	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret	ired)					
thin 36	훁	10 0 Home Tangavine	1	Self .	2 malayed			
od will	Completed		e (First, Middle, M	laiden Surname)	- HOLOGEN			
215 e file tal H ked o	Be	Howard Taylor Rac	hoi	Neal	• •			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	5	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	Rural Route Num	ber, City or Town, State	e, Zip Code)			
AD 2 sho h and 27 is	. 1	Ms. Tyra Taylor 524 Val. Ave.	Bal.	to. Mo	21229			
e, and Health		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State			
IOT 1968 ] 11 of 1		1 Burial 2 Cremation 3 Removal from State crematory or other place)		*	4.4			
timen trans	- 0	4 Denation 5 Other Specify: 1 Cinity Cemetery (a) 21. Signature of Funeral Servic Licens 2 and Address of Fullips	11/2012	Dundal	< Mo			
Bal Departiment	- 1	21. Signature of Funeral Servic Licens and Address of F cilians	s Fulls	ival Home,				
	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of the disease.	or respiratory arre		Approximate Interval			
Physician /Medical		failure. List only one cause on each line.	or respiratory arre	st, shoot, of ficare	Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death)  Para to (or as a consent ence of):			Death			
and the same		or condition resulting in death)  [Fue to (or as a consequence of):						
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-			
	🚊 cause. Enter Underlying Cause							
, S	xa	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
executed in and il - transit	calE	d.						
ਡ ਜ਼ਿਵ ਜ਼ਿਸ਼		▼ UNPENDED						
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physicial prietly filled in by the funeral director, page 2 should be detached for use as the buril	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	у			
68 ertifi ding	an	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant in the past 12 months?	ancy	Month I	Day Year			
OX 687 eath certific	Sic	4 Pregnant at time of death 5 Other (Specify) 9 Unknown						
the de the	چ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tot	bacco use contribute to	the cause of death?			
P.O.	ğ	Taken. Other argumetatic continuous Continuously to death but not resulting in the underlying cause given in raint.		2 No 3 Prol				
S, P uires t n sign				211				
ords, w requires been should	Completed		24a. Was a autops	sy prior to o	topsy findings available completion of cause of			
Reco The law icate has	틹		perform		es 2 No			
of Vital Records, g. Physician: The law require ther this certificate has been si meral director, page 2 should be		25. Was case referred to medical 26.Place of Death (Check						
Vita hysicia this ce	o Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursin	ng Home 5 F	Residence 6 🗸 Othe	r: Scene			
ding Phy.	-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred				
DD on the furth.	흔	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No						
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fa	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	treet and Number or Ru	ral Route Number, City			
Est or saft in the control of the co	딅	Suicide Could not be determined (Specify)	or Town, St					
Hospital 24 hours a Funeral tely filled		29a. Certifier 1 Coals to Physician To the heat of my knowledge death accorded to the line date and also	L due to the source	c/s) and manner so stat				
To the E within 24 To the F complete	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yea							
To the within To the comple	ş	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	nth Day Year)			
Dis		O.C.M.E.		June 2, 2012	, 55, 75017			
(1),		100000000000000000000000000000000000000		June 2, 2012				
mard		30. Name and address of person who completed cause of death (Item 23a)	MD 04000					
Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 0 8 2012  32. Registrar's Signature						
	_							
DHMH 17 Rev 1/20	001	ORIGINAL		OCME				

	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg No 2 0 1 2 1 8 2 5 0									
200			No. 20 2 8250							
Physician Medica Examine			1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month	Day Year 9:15 6 M				
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
Tanas (			VILLA ROSA NURSING HOME  5. Social Security Number 6. Sex 7. Age (In vrs. last birthda)		PRINCE GEORGE'S					
	Funeral Director		5. Social Security Number 579-46-8429  Usual Residence of Decedent  6. Sex 1 X M 2 G F 7. Age (In yrs. last birthda) 7 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea APRIL 7	9. Birthplace (State or Foreign Country) WASHINGTON, DC				
	land shov dat	to	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits				
nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland st of Heath and Mental Hygiene. if friem 27 is marked other than "natural", or items 23a or 28a-f show	28a-	Director	MD PRINCE GEORGE'S LANDOVER			¥☐ Yes 2 ☐ No				
	ith the		100. Street and Number	10f. Zip Code		Citizen of What Country?				
	ems	Funeral	1401 BELLE HAVEN DRIVE  11. Marital Status  12. Was Decedent Ever in U.S.  13. Marital Status	20785  3. Was Decedent of Hispanic Origin? (Spec	ify Yes or No-	USA  14. Race - American Indian,				
	urs after de ural", or it Il Examine	by	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2X No Specify:	ican, etc.)	Black, White, etc. Specify: BLACK				
21215-0036	thin 72 hou sne. than "nat ne Medica	Completed	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4 or 5+)	pedent's Usual Occupation re kind of work done during most of working DO NOT use retired)	g 16b	o. Kind of Business/Industry				
d 2	filed wi al Hygie d other event, tl	Be (	10th  17. Father's Name (First, Middle, Last)	BRICKMASON  18. Mother's Name	First Middle Maid	PRIVATE				
rylan	should be fil n and Mental r is marked raumatic ev	2	ESAW TAYLOR	IRENE BU		en dunane)				
, Mal	and 2 sho Health and tem 27 is r			illing Address (Street and Number or Rural in BELLE HAVEN DRIVE						
~	Page 1 al ment of H ant: If iter ury or oth		1 Burial 2 TCremation 3 Removal from State cemetery, cr	position (Name of Date of the Position (Name of Position). The CREMATORY 6/12/		E. Location - City or Town, State  VERDALE, MARYLAND				
Balti	permit. Page Department Important: Ii any injury or			22. Name and Address of Facility $  {f J}  . $	B. JENKI	NS FUNERAL HOME, INC.				
23a. Part 1. Enter the disease, or complications that caused the death. Panot enter the mode of dying, such as cardiac or respiratory arrest,  Approx										
~~~	Physician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Ganquere	Left Foot		Interval Between Onset and Death				
	Medical Examiner		resulting in death)  Due to (or as a consequence of):	ascular Disease						
	ı ti	iner	if any, leading to immediate Due to (or as a consequence of):	25 CCC 1861 11 25005 E						
	te be executed nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
09	ite be e hysicia the bur	dical	<b>L</b> d							
587	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent program: 23c. If yes, outcome of pregnancy							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year				
P.O.	that the ned by e deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?				
ds,	quires en sig ould b	ted b	Un sepsis		1 🗆 Yes	2 No 3 Probably 4 Unknown				
Division of Vital Records,	The law re ate has be page 2 sh	Completed by	End Stage Kidney Disease		24a. Was an autopsy performed					
ta	Physician; T r this certifica eral director, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Check of		1 100 2 2 100				
<u> </u>	Physi this o	Certificate: To	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manper of Death 28a. Date of injury 28b. Time			6 Other (Specify)				
0 0	th. : After e fune		1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident Investigation	of 28c. Injury at work?  M 1 □ Yes 2 □ No	d. Describe how in	jury occurred				
IVISIO Or Atten after deat	l or Atter after des Director d in by th		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)		Bf. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)				
	dospita 4 hours funeral tely fille	Medical	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invo	vsician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	o the l	Me	only one) 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	- > - 0		29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)							
So Name and address of person who completed cause of death (Item 23a) (Type, Print)  Down thy Secry no 3500 Lotts for I Vista Rd Mitchelly										
	State Registrar JUN 0 8 2012 32 Registrar's Signature August 2. Aparls									
_										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth 5. 2012 8:29 A June 6, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1404 Ellenglen Road Baltimore Towson 5. Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) November 24, 1933 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral Director** 219-32-4915 1 M 2 XF 78 Pennsylvania Usual Residence of Dec or 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗌 Yes 2 🙀 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DOD 6/6/2012 23a Funeral 1404 Ellenglen Road 21286 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical 5+ <u>Director of Nursina</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas M. Scanlan, Sr. Catherine Stafford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Fitzpatrick (nephew) 22 W. Pennsylvania Ave. Suite 606 Towson, Maryland 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Elizabeth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gdns. 6/11/2012 Timonium Maryland 21. Signature of An Al Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ptemician/ Motor 1 month neuron disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician ar s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Month Pregnant at time of death Year 5 Other (specify) Day 1 ☐ Yes ∠ ∉ 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 X No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after death.

The Funeral Director: After this objetely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the I

comple 051807 Mr Mm. MD June 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Gloria Yim, MD

JUN 0 8 2012

31. Date filed (Month, Day, Year)

32. Registrar's

419 W. Redwood St. Ste 620 Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8 55 200 Joseph Thorn Wall Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner - Keed Memorial al 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (\$tate or Foreign 7. Age (In yrs. last birthday) **Funeral** 515-12-1211 Min Director 1 🛛 M 2 🗆 F 86 2/1/26 Kansas 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location with the Maryland notified at Director Washington MD Boonsboro 28a-f 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be hommen Funeral 21713 6012 Moser Road 23a USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian ed Forces? Yes 2 No the Medical Examiner Black, White, etc ō þ 1 Never Married 2 Married XX Yes Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Govt. N.A.S.A Electrical Engineer 12 Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Thornwall Katie Joseph William Eva Lesser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6012 Moser Rd, Boonsboro MD 21713 Thornwall / Son Greq Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation XX Removal from State cemetery, crematory or other place) 5/23/2012 Penwell-Gabel Cemetery Topeka, Kansas 4 Donation 5 Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 ature of Funeral Service Licensee Victor Doda 8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, 335 30. Name and address of pers on who completed cause of death (Item 23a) (Type, Print) 1126 Opel Ct. Nanc Hagestown

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month Day

Year

IIIN 0 8

Registrar's Signature

			Please <sup>-</sup>	Type or Print in B AMEND TITEM#17 State of Maryland	lack Indelible In	k, Ensure	All Copies A	Are Legible	
		_	For State Registrar	State of Maryland	Certificate of L			. No. 201	2 18253
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ali Ce		Washingto	n	2. Date of Death Month	Pay 2012	3. Time of Death
	Examin Funeral		4a. Facility Name (if not institution, give s The Johns Hop 5. Social Security Number 6. Sex	Kins Hospita	Baltin St birthday) If Under Year	or Location of Death	8. Date of Birth	4c. County of Dear	rthplace (State or Foreign
	Director ≥	tor	216-22-4617 1 Usual Residence of Decedent 10a. State 10b. County	M 2 F 84	Yrs. Months Days Town or Location	Hours Min,	(Month, Day, Ye		10d. Inside City Limits
	a or 28e-f be notified	Funeral Director	10e. Street and Number	<u>t</u>	Baltin 10f. Zip Code	nore	10ς	g. Citizen of What Co	1 √res 2 ☐ No ountry?
	ath with	uner	23 28 Eu	Faw Play  12. Was Decedent Ever in U.S.	e a	1121-	7	us	š A
9600	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28e-f sho event, <u>the Medical Examiner must be notified at</u>	à	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cube  1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Deciry Yes or No- Deciry Yes or No- Deciry Yes or No-	14. Race - Ame Black, Whit	
Maryland 21215-0036	ithin 72 ho iene. r than "na the Medic	Completed	15. Decedent's Edu (Specify only highest grad Elementary Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of world	king 16	ib. Kind of Business	/Industry
/land?	uld be filed w Mental Hygi narked other retic event,	ادە ا	17. Father's Name (First, Middle, Last)	Young	10112	18. Mother's Nan	me (First, Middle, Maid	den Surname)	I 10/WZ
	2 shouth and the and 27 is not traum.		19a. Informant's Name/Relationship (Typ	e, Print) (Day note)	19b. Mailing Address (Street a	and Number or Rui	ral Route Number, Cit	ty or Town, State, Zi,	ip Code) 0 21217
Baltimore,	. Page 1 and ment of Hea tant: If item iury or other	(= \$1	20a. Method of Disposition  1  Burial 2  Cremation 3  F  4  Donation 5  Other (Specify)	Removal from State 20b. Pla	ace of Disposition (Name of metery, crematory or other place	ton 6 9	Date 20	c. Location - City or	
Balt	permit. Page 1 Department of Important: If i eny Injury or o		21. Signature of Funeral Service Licensed	Gray	2222 V	ess of Facility R	uss Fun	evoil to	ne, P. A. Mo 21216
Į	Physician/ , Medical		23a. Part 1 Enter the disease, o complishool, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. a.  Due to (or as a conseque)	Sis	ng, such as cardiac	or respiratory arrest,	<i>y</i>	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate						
D	executed an end irial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):			1	
68760	certificate be nding physicia use as the bu	edica		J					
	res that the death certificate be executed signed by the attending physician end die detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1  Live Birth 2 Fetal ( 4  Pregnant at time of deady I Unknown	death 3 Ectopic pregnand	су		23d. Date of de Month	elivery Day Year
ds, P.O.	Hospital or Attending Physician: The law requires that the death 24 hours after death. Funerel Director: After this certificate has been signed by the attertely filled in by the funeral director, page 2 should be detached for	ed by P	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying cause giv	ven in Part I.		<b>1</b>	o the cause of death?  Probably 4 Unknown
Records,	The law rec ate has ber page 2 sho	Completed by					24a. Was an autopsy performed	prior to death?	ntopsy findings available completion of cause of
/ital	sician: certific lirector,	B B	25. Was case referred to medical examiner?	ospital:		lace of Death (Chec	ck only one)		
of Vital	ig Physical dineral d	te: To	27. Manner of Death	1 Mpatient 2 L El	8b. Time of 28c. Injury	4 ∐ Nursing H y at	ome 5 Residence		:ify)
Division	uttendin death. ctor: Aft y the fu	tifica	1  Accident			k?  Yes 2 □ No			
Divi	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certificate:	4 ☐ Homicide determined  29a. Certifier 1 ☑ crtifving Physic	building, etc. (Specify)	ne, farm, street, factory, office	d-transfelone	28f. Location (Stree City or Town, St	tate)	
	To the Hospital within 24 hours a To the Funeral C completely filled		only one) 3 Certifying Nurse	er: On the basis of examination a  Practitioner: To the best of my	and/or investigation, in my opinic	on death occurred a	at the time date and of	lace and due to the	course(s) and money stated
			29b. Signature and title of certifier	leh		5-000	29d.	Date signed (Mont)	h, Day, Year) 2012
	3			losen		1800 N	Orleans Si	+. BaHimi	ore, MD 21287
	Stat Registra	e ir	JUN 0 8 2012	32. Redistrar's signatur					

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death Month **5** 1. Decedent's Name (First, Middle, Last) Physician/ Year Medical Elizabeth Josephine Wendelstedt June 6, 2012 10:40 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1322 East Riverside Avenue Baltimore Essex 7. Age (In yrs. last birthday, If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Director 219-16-6684 Usual Residence of Decede 1 🗆 M 2 💢 F 93 10/10/1918 Maryland show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No Maryland Baltimore Essex ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1322 East Riverside Avenue 21221 U. S. A. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Medical Examiner Armed Forces 9 q 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Specify. Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 9 Homemaker Own Home traumatic event. Be 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) မှ William Aaron Lusby Josephine Blum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Janet Wheeler (Daughter) 8366 Woodland Road Millersivlle, Maryland 21108 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o ç 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/7/2012 Crematory Baltimore, Maryland Bayview Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Ofset and Death Immediate Cause (Final Physician/ ACCIDEN CEREBROVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? gned by the atter Month Day Year 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pagt I. 23e. Did tobacco use contribute to the cause of death? Completed by Coror illart Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown pollroso 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2M No certificate has 2 No 1 Ves 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 1 X Natural 28c. Injury at work? Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending injury 5 Pending s after death. 1 Yes 2 No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D18326 6/6/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Essex Medical Couter, 404 Eastern Blod, Baltimp NAGEM GAUHAR,

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

mo ,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Dece<u>de</u>nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June ONSUEID 2013 3:35PM Iamson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Prince Hospita George's Laure 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Months 329-48-2495 1 □ M 2 🛣 F Director 57 Sep 20, 1954 Illinois Usual Residence of Deceden 28a-f shov 10b. County items 23a or 28a-f sho 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 Tho MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2995 Lost Creek Drive 20724 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ▼ Yes 2 □ No 1983
If Yes, Give
Year or Dates. −1988 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 X o Specify: Specify: African American "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) + Artist Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Joseph WIlliamson Consuelo Alcainas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trae Joseph Williamson brother 2995 Lost Creek Blvd. Laurel, Maryland 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XX remation 3 Removal from State West Arundel Crematory 6/8/2012 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup>. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, / M00770 23a. Part 1. Enter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Lis only one cause on each li Immediate Cause (Final Physician/ Teumo nia disease or condition resulting in death) Medical Due to (or as a consequence of): Multiple Sclerosis Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Luc to for as a consequence on sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 phys the t IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes 2 9 ☐ Unknown Unknown P.O. signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No Hospital or Attending Physician: The 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 🗌 Yes ည 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending after death. 1 🗌 Yes 2 No Accident Investigation ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sign 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

aurel

Regional

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamed Tourky

69247

Hospita

7300 Van Dusen Road

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TUNES Kenneth Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctor's Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last hirthday 8. Date of Birth **Funeral** Days Jan 11, 1957 Director 579-78-6747 1**X** M 2 □ F Washington, DC 55 Usual Residence of Decedent 28a-f show 10a, State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, <u>the Medical Examiner must be notified</u> at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Upper Marlboro 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4409 Sutherland Circle 20772 United State Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 If Yes, Give 1981 Year or Dates. 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black VILLAIS, KONDIT 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired College (1-4 or 5+) Elementary/Secondary (0-12) Information Technology Private and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Randolph Williams Flossie Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Christine D. Williams/Wife 4409 Sutherland Cir; Upper Marlboro, MD 2077 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Ft. 4 Donation 5 Other (Specify) Lincoln Cemet. 6/9/2012 Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility JB Jenkins Funeral Home Naphnel 7474 Landover Rd; Hyattsville, MD 20785 23a. Part 1. Exert the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cau, on each line. such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Phylician disease or condition Medical resulting in death) Examiner a Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-t Physician/Medical that the death certificate be Box 68760 the th use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death the P.O. ed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has I autopsy performed' 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work n 24 hours after death. le Funeral Director: Al bletely filled in by the fu 1 Tes 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2, To the F complet only one) 29b. Signature and ti D64268 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Lanhow Maryland 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month JUNE WOOTEN 9:00 РМ L. WARREN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** AUG. 14 Year) 944 1 🌠 M 2 🗆 F NORTH CAROLINA **Director** 241-68-7425 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director BRYANS 1 Yes 2 No MD CHARLES 10g. Citizen of What Country? 10f. Zip Code 20616 Funeral 2550 BOLINBROOK COURT death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: "natural", 3 Divorced 4 Divorced Year or Dates. nt of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE TRANSPORTER 11thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EVA MAE SANDERS HILLARY WOOTEN . Page 1 and 2 should b ment of Health and Mei tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2550 BOLINBROOK COURT BRYANS ROAD, MARYLAND 20616 THERRICKA L. COBEY/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Department of Important: If any injury or RIVERDALE CREMATORY | 6/11/2012 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses ► Warphney 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death immediate Cause (Final Physician/ END STAGE RENTL disease or condition resulting in death) Medical Examiner ARTERY DRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam HYPERTEWSION and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death 1 Live Birth 2 Live Feat 4 Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) 2 No signed by the a d be detached f 1 ☐ Yes 2 L g ☐ Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HUMAN IMUNODEFICIENCY VIRUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 I DOA 2 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 🗌 Yes 2 🗎 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JUN 0 8 2012

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TORM JODRIE, MD, FACEP - FLOO CARLULL MD, FACEP. 32. Registrar's Sinature,

29c. License number D40324

AUENUE, THROMA PARK, MARYLAND

18258	
-------	--

		- State Registrar  Amend Item 24a per dr.,	Certificate o	f Death		Reg. No.	
Physician	,	1. Decedent's Name (First, Middle, Last)	-		2. Date of De Month	Day	3. Time of Death
Medica		Dorothy Marie Wright			May 11		4:18 PM M
Examine	er	4a. Facility Name (if not institution, give street and number)		n, or Location of [	Death	4c. County	
		7420 Parsonsburg Road		onsburg	Hrs. To Buy (B)		comico
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. $1 \square M 2 \square F$	Months Da		Hrs. 8. Date of Bir Min. (Month, Da		<ol> <li>Birthplace (State or Foreign Country)</li> </ol>
Director		073-30-1802 1 □ M 2 🗶 F Usual Residence of Decedent 7.	5 Yrs.		Dec 8,	1936	New York
ind show	5		ity, Town or Location				10d. Inside City Limits
laryla	ect	MD Wicomico	Parsonsburg				1 🗆 Yes 2 🛣 N
or 2	₫	10e. Street and Number	10f. Zip Coo	e		10g. Citizen of \	What Country?
with 23a ust b	era	7420 Parsonsburg Road		21849		US	SA
leath Items er m	Funeral Director	11. Marital Status 12. Was Decedent Ever in L Armed Forces?	I.S. 13. Was Decedent of	of Hispanic Origin	? (Specify Yes or No- Querto Rican, etc.)		e - American Indian,
within 72 hours after c glene. er than "natural", or t, the Medical Examin	ρ	1 Never Married 2 X Married 1 Yes 2 X No	1 ☐ Yes 2 <b>∑</b>		, , , , , , , , , , , , , , , , , , , ,	Specify.	ck, White, etc.  white
urs a tural'	ted	3 ☐ Widowed 4 ☐ Divorced Year or Dates.					
72 ho	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use retii	ne during most of	f working	16b. Kind of B	usiness/Industry
ithin ene. thar	S	Elementary/Secondary (0-12) College (1-4 or 5+)	homemaker	,		own h	OMA
Hygi Other ent, t	Be (	17. Father's Name (First, Middle, Last)	Homemaker	1	s Name (First, Middle		
be fill ental ked c	၉	Sven Nielsen		Sor	ohie Koeni	.g	,
ould Mar mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Str.				State, Zip Code)
12 should be filed alth and Mental Hy 27 is marked oth r traumatic event	1	Louis Wright/spouse			Road Pars		
1 and if Hea item		_	Place of Disposition (Name of		Date	20c. Location -	- City or Town, State
age lent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 💢 Donation 5 ☐ Other (Specify)	cemetery, crematory or other	orace)			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentia Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.		21. Signature   Funeral Service Licensee   Directo	22. Name and Ag	dress of Facility	oard 655 I	J Ralti	more Street
an Je		S. Wille Vitecto	Baltimo	_		v. Daren	more street
		23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	ath. Do not enter the mode of	dying, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between
Physician!		Immediate Cause (Final disease or condition	Gril Non Hod	Kins Ly	n Dlong.		Onset and Death
Medical		resulting in death)  a. Let to (or as a constitution)	quence of):	)	1		
Examiner		Sequentially list conditions					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quei ice oij.				
cuted	каш	Cause (Disease or injury that initiated events c.					
e exerian a	<u>=</u>	resulting in death) Last Due to (or as a conse	quence ot):				
rificate be executed ng physician and as the burial-transit	Medical	d					
ertifica ding p		IF FEMALE: 23c. If yes, outcome of pregi	nancy			00.1.0	A of dellar
death certine attending the attending to the attending the	ian	in the past 12 months?	etal death 3 🔲 Ectopic pregi				nte of delivery onth Day Year
the a	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	r death 3 - Other (speed)	/			
requires that the des been signed by the s should be detached	4	Part II. Other significant conditions contributing to death but not re	esulting in the underlying caus	e given in Part I.	23e. Did	tobacco use cont	ribute to the cause of death?
sign sign	d by				1 🗆	Yes 2 No	3 Probably 4 Unknow
The law requires: ate has been sig- page 2 should b	Completed				24a. Was	s an 24b.	Were autopsy findings available
e law e has ige 2	m				auto	ormed?	prior to completion of cause of death?
sician: The law r certificate has b director, page 2 s		25. Was case referred / medical	26	Place of Death	(Check only one) ✓	2 A No	1 Yes 2 No
s cert direct	To Be	examiner?  1  Yes 2 No Hospital:		Other:	sing Home 5 Res	idence 6 \( \text{Oth} \)	er (Specify)
Phys this		27. Man r of Death 28a. Date of injury	28b. Time of 28c. I	njury at	1	how injury occurr	
B 6 6	Ψ.	Natural 5 Pending		vork?	lo		
ath. r: After re fune	icate	2 Accident Investigation		ce	28f. Location	(Street and Numb wn, State)	er or Rural Route Number,
Attending Physician: The law requires that the death certificate be executed er death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ertificate	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, street, factory, off				
tal or Attending Irs after death. al Director: After led in by the fune	al Certificate:	3 Suicide 6 Could not be			Gity Gi 70		
dospital or Attending 4 hours after death. uneral Director: After ely filled in by the fune	dical Certificate	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	ify) wledge, death occurred at the		ace, and due to the	cause(s) and mani	
the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi mpletely filled in by the funeral director	Medical Certificate	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. Spec  29a. Certifier (Check only one) 3 Certifying Physician: To the best of my known only one) 3 Certifying Nurse Practitioner: To the best of examinate only one)	wledge, death occurred at the ion and/or investigation, in my of my knowledge, death occurred	pinion, death occu at the time, date	ace, and due to the curred at the time, date	cause(s) and mani and place, and du the cause(s) and r	e to the cause(s) and manner sta manner as stated.
i Pitte	Medical Certificate	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. Spec  29a. Certifier (Check 2 Medical Examiner: On the basis of examinat	wledge, death occurred at the ion and/or investigation, in my of fmy knowledge, death occurred 29c. Lic	pinion, death occul at the time, date ense number	ace, and due to the curred at the time, date	cause(s) and mani and place, and du the cause(s) and r	e to the cause(s) and manner sta
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Certificate	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. Spec  29a. Certifier (Check 2 Medical Examiner: On the best of my known only one) 3 Certifying Nurse Practitioner: To the best of examinat only one) 29b. Signature and the of certifier	wledge, death occurred at the ion and/or investigation, in my of my knowledge, death occurred 29c. Lic	pinion, death occu at the time, date	ace, and due to the curred at the time, date	cause(s) and mani and place, and du the cause(s) and r	e to the cause(s) and manner sta manner as stated.
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral presents of the funeral p	Medical Certificate	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Check 2 Medical Examiner: On the basis of examinationally one) 3 Certifying Physician: To the best of my known Medical Examiner: On the basis of examinationally one) 3 Certifying Nurse Practitioner: To the best of certifier  30. Name and eddress of person who completed cause of death (Ite	wledge, death occurred at the ion and/or investigation, in my of fmy knowledge, death occurred 29c. Lic	pinion, death occul at the time, date ense number	ace, and due to the curred at the time, date	cause(s) and mani and place, and du the cause(s) and r	e to the cause(s) and manner sta manner as stated.
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. Spec  29a. Certifier (Check 2 Medical Examiner: On the best of my known only one) 3 Certifying Nurse Practitioner: To the best of examinat only one) 29b. Signature and the of certifier	wledge, death occurred at the ion and/or investigation, in my of fmy knowledge, death occurred 29c. Lic 29c. Lic 29c. 23a) (Type, Print)	pinion, death occul at the time, date ense number	ace, and due to the curred at the time, date	cause(s) and mani and place, and du the cause(s) and r	e to the cause(s) and manner sta manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** AM Verna 200 7:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) July 13, Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🂢 F 1938 Maryland Director 73 214-34-4547 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County 28a-f show 1 ☐ Yes 2X No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 272 any injury or other traumath. 21222 USA 1701 Drexel Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD Precision Spring Factory Worker / Finisher 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Griffin Alva Cosner ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1701 Drexel Road, Dundalk, Maryland 21222 Christopher Wilson son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition June 9. 1 XBurial 2 Cremation 3 Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery: 2012 of Funeral Service Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. nediate Cause (Final Physician disease or condition resulting in death) basilar embolic stroke / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy Month Day Year In the past 12 months?
1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) PO. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1. Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

parker

29c. License number

RES-OOC

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

6

and manner stated.

Brudno, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and numi **Examiner** Ou If Under 6. Sex If Under 24 Hrs 9. Birthplace (State or Foreign ocial Security Numbe **Funeral** Months Min (MO97:133/19975 Carriew York 079-03-4995 1 🗆 M 2 🔽 96 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural?" any injury or other traumatic averal. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 USA 3010 North Ridge Road #400 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married Married 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public School Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harriet Macomber Burton Cavanaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Greenleaf Road, Cheverly, MD 20785 Sarah Kaminski / Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 6/8/2012 Beltsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ near+ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No for Month Day Year Pregnant at time of death 1 Yes 2 page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🎾 No Hospital 2 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After work? 1 Yes 2 No injury Natural 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ,0

State

Registrar

31. Date filed (Month, Day, Year,

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 0 1 2 Physician/ MINNIE WICK JUNE 5 8:45A M Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7911 HILLTOP AVENUE NOTTINGHAM BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 91 Yrs Days 1 M 2 X X (Month, Day, Year) 12-22-1920 218-07-6169 MARYLAND Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director BALTIMORE NOTTINGHAM 1 Yes 2 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a 36 BARTLEY COURT 21236 U.S.A. if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 V Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANGELO MAGNONI MARY FLORIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau CYNTHIA VanCAMP/DAUGHTER 7911 HILLTOP AVENUE NOTTINGHAM, 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 6-6-2012 CATONSVILLE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MONRY hours disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No Pregnant at time of death 5 Other (specify) g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 autopsy performed? this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 2 No 6 Other (Specify DAUGHTER 'S 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury HOUSE injury 1 Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) AttendiNG D17118 5,2012 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) 7 MD 3512 chwar 72 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MO6/06/2012 9:45P MALLORY YEARLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** None Baltimore Keswick If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 93 214-14-8652 1 □ M 2 🂢 F Director Yrs 10/31/1918 Maryland Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director YX Yes 2 ☐ No Maryland None Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be r Funeral 21211 USA 700 West 40th Street items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, "natural", or item edical Examiner n 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Model. Elementary/Secondary (0-12) College (1-4 or 5+) Technician Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Durant Church Alexander Yearlev III 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 West 40th Street #651 Baltimore, Maryland 21212 Dorsey Yearlev Brother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State GreenMount Crematory 06/11/2012 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service Licensee 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ENDSTAGE dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner pue to lor às à consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ass IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atter in the past 12 months? Month Dav Year Pregnant at time of death Unknown 2. No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ exchrovas cular Accupent 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? pollyroid 24a. Was an page 2 has autopsy performed? certificate l 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this nin 24 hours after death. the Funeral Director: After this apletely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

To the 2 within 2 To the 3 comple

State Registrar 4 wow ommo

29b. Signature and title of certifier

Hilary

5901 North

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

35102

Street

BAL

29d. Date signed (Month, Day, Year)

2012

une

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mooth Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death **Examiner** Washingy 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Months Hours Min Director 1 🕅 M 2 🗆 F Yrs 1 May 20, 2012 Maryland 1 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10123 Mar Rock Dr. 21740 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. þ 1 XNever Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kaylah Marie Boone Ian Michael Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10123 Mar Rock Dr. Hagerstown, MD 21740 David Armstrong-grandfather 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. XBurial 2 Cremation 3 Removal from State Rest Haven Cemetery 6-1-2012 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service L Eastern Blvd. North Hagerstown, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 X No 1 Yes ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number 5457 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar MO

30

31. Date filed (Mon

Imperal

	d#26 per		y . 5-22-12 kan	Please	Type or Pr									_	ble.	
HHU	nearui L	qı.	For State	1	State of N	/laryland					and M	ental Hy	giene	€		
			Registrar  1. Decedent's Name (I	First Middle Las	t)		Cer	tificate	of L	eath		2. Date of De	Reg. N	° 20	11	2 18264
	Physicia Medic			W. Bagn								Month May 19		012	Year	9:08 p M
	Examin	er	4a. Facility Name (if no 523 Coove		street and number)	)		4b. City, To		Location o	of Death		40	c. County o		rundel
	Funeral		<ol><li>Social Security Num</li></ol>	nber 6. Se		ge (In yrs. la	st birthday)	If Under 1	-	If Under Hours	24 Hrs.	8. Date of Bir (Month, Da		T	g. Birth	nplace (State or Foreign
	Director		536-22-64. Usual Residence of I		<b>X</b> м 2 □ F	87	Yrs.	IVIOITIIS	Days	Hours		May 15		1		th Dakota
	rland f show d at	tor		10b. County		10c. City	, Town or Loc	cation					,			10d. Inside City Limits
	e Mary r 28a- notifie	Direc	MD 10e. Street and Number	Anne Ar	undel			A 10f. Zip (		polis	3		10.0			1 🗆 Yes 2 🗓 No
	with th	Funeral Director	523 Coov					1	214(	01			Tug. C	itizen of W	nat Col	intry?
	death items ner mu	Fun	11. Marital Status		12. Was Deceden Armed Forces	?	. 13. V	Vas Decede Yes, specif	nt of His	spanic Ori	gin? (Speci	ify Yes or No- ican, etc.)			- Amer	ican Indian,
036	s after ral", or Exami	ed by	1 Never Married 3 Widowed 4	**	1 X Yes 2 I If Yes, Give Year or Dates.		mv I	☐ Yes 2						Specify:		ite
5-0	2 hour "natu edical	Completed		15. Decedent's Ed fy only highest gra	ducation	Į	(Give F	lent's Usual kind of work	done di		t of working	g	16b. i	Kind of Bus	siness/l	ndustry
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Com	Elementary/Second	dary (0-12)	College (1-4 or	r 5+)		ONOTuser <b>lachi</b> n					De	lco E	Batt	ery
pu	filed v tal Hyg d othe event,	To Be	17. Father's Name (First							18. Moth		(First, Middle,			-	
Maryland	ould be id Men marke matic		George  19a. Informant's Name	H. Bagne			10h Mailia	o Address (	24	and Alexander		Route Numbe			-A- 7:	Contai
	id 2 sh salth ar n 27 is er trau		Dorothy M									olis,			аге, Zip	Code)
Baltimore,	ge 1 an it of He If iten or oth		20a. Method of Dispos		Removal from Stat	te ce	ace of Dispo	natory or oth	er place			ate 0010	I		-	Town, State
ltim	nit. Pac artmen ortant: injury injury			Other (Specif	y)	Lak	emont			i_		-2012 11 Fun				11e, MD
B	Depar Impor any ir		( ODD)	marie	TED	ald						Bowie				20715
			shock, or heart f	failure. List only or	olications that caus ne cause on each li	ne.			1	, such as	cardiac or	respiratory ar	rrest,			Approximate Interval Between
ā	Physician/ Medical		Immediate Cause (Fir disease or condition resulting in death)	nai		s a conseque		rre	st			4 1			-	Onset and Death
700	Examiner	Ĺ	Sequentially list cond	ditions	, ele	ctro	lust	2 0	6.	nov	mo	lit	4			3 days
	ed nsit	Examiner	if any, leading to infin cause. Enter Underlyi Cause (Disease or inji	ing	Due to (or a	s a consequi	erige of):	tion								/wks
	executed an and rial-transit	I – I	that initiated events resulting in death) Las		Due to (or a	s a conseque	ence of):	110	21						$\dashv$	· ·
09,	cate be o	Completed by Physician/Medica		-	d. Sev	Jer	ed	eme	-Vi	tie	<u> </u>				$\dashv$	Syears
Box 68760	eath certifica attending p	n/Me	IF FEMALE: 23b. Was decedent pre	regnant	23c. If yes, outcom			1						23d. Date	e of deli	verv
Box	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physici stely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	/sicia	in the past 12 mo 1 ☐ Yes 2 ☐ I 9 ☐ Unknown		1	at time of de	eath 5	Other (spe	egnancy cify)	/				Mon	th	Day Year
P.O.	es that the igned by 1 be detacl	y Ph	Part II. Other significa	ant conditions of	ontributing to death	but not resu	ılting in the u	nderlying ca	use give	en in Part	1.	23e. Did t	obacco	use contrit	oute to	the cause of death?
ds, l	requires t been sign should be	ted b	1/2	elrei	mers	di	50 a	se				1 🗆	Yes 2	: No :	3 🗌 Pro	obably 4 🗆 Unknown
COL	law rec has be	nple	Core	snan	y ar	ter	4 0	Lisc	a	se		24a. Was auto	psy	pr	rior to c	opsy findings available ompletion of cause of
E Re	ilcian: The law certificate has rector, page 2.		25. Was case referred	onic to medical	Irena	<u>-1 t</u>	tei (	ure	26 Dla	as of Dan	ith (Check o	1 🗌 Yes	ormed?		eath?	2 No
Vita	Physicia this cert ral direct	To Be	examiner? 1 🗌 Yes 2 🗗	No	Hospital: 1 🔲 Inpa	atient 2 🗆 E	R/Outpatien	t 3 🗆 DOA	Othe	r	/	ne 5 🔀 Resi	dence	6 🗌 Other	(Speci	fy)
Division of Vital Records,	ding Pl h. After th funera			5 Pending	28a. Date of in (Month, D	jury Jay, Year)	28b. Time of injury	286 M	work?	at Yes 2 🗆		3d. Describe l	how inju	ry occurred	d	
isio	il or Attendi after death. Director: A d in by the fi	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation  6 Could not be determined	e 28e. Place of Ir	njury - At hor	ne, farm, stre			res 2					or Rura	al Route Number,
Οįν	oltal or urs aftu eral Dir illed in			/	D	etc. (Specify)						City or Tov		<u> </u>		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in E	Medical	(Check 2 L	Medical Exami	sician: To the best on ner: On the basis of se Practitioner: Jo	examination	and/or invest	igation, in m	opinion	n, death or	ccurred at the	he time, date a	and place	e, and due	to the c	ause(s) and manner stated.
	To th To th Comp	-	29b. Signature and tit	7	1.	- 1	11	29c. l	icense	number	(0.	_				Day, Year)
	W (		20 Nome of did	a of porce when	Jensy (	dooth (train	220) (5: 5	1	00	059	140	5	0	5/	12	12012
	ASOL,		Trederi	ick K	completed cause of	_ / -	ZJaj (Type, P	S Inti)	15	70 4n	nan	3 - /-	no	MSD.	TZ	1401
	Sta Registra	le ar	31. Date filed (Month,	2 2 2012	32. Regis	trar's Signatu	fac	~			1					

		Please '	Type or Print in				•	0	ole.
		For State	State of Marylar				lental Hygie	ene	
		Registrar  1. Decedent's Name (First, Middle, Last)	)	Cer	tificate of D	Death	Reg	3. No. 20	12 18265
Physicia: Medic		Victoria	,	Ва	rros		May 13	Day 2012 Y	ear 8:27 A M
Examine	er	4a. Facility Name (if not institution, give s 8201 Ft. Foote	,		-	Location of Death		4c. County of <b>Prin</b> (	Death Ce George's
Funeral Director		5. Social Security Number 6. Set 579–54–1553 1 E	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 07/21/19	0	Birthplace (State or Foreign Country) Philippines
aryland la-f show ified at	Director	10a. State 10b. County		ty, Town or Loc Ft. Was	ation shington	<u></u>			10d. Inside City Limits 1 ☐ Yes 🏋 No
with the M	Funeral Dir	10e. Street and Number 8201 Ft. Foote	Road		10f. Zip Code	20744	100	g. Citizen of Wha	at Country?
, or	ρ	11. Marital Status  1  Never Married 2  Married  3 X Wildowed 4  Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes ŽŽ No If Yes, Give Year or Dates.		/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Black, 1	American Indian, White, etc. Filipino
within 72 hou giene. er than "natu t, the Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12 years		(Give k	ent's Usual Occupa ind of work done o NOT use retired) Transpor	luring most of worki	ng	Stb. Kind of Businederal (	ness/Industry Government
l be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Ulpiano Olie	Palmani			18. Mother's Name	e (First, Middle, Mai Rubiado	den Surname) Oque	ndo
nd 2 should ealth and N m 27 is ma			pe, Print) / Daughter			and Number or Rura e Road Ft		ty or Town, State	e, Zip Code)
Page 1 a Iment of H tant; If itel jury or oth		20a. Method of Disposition  1 💹 Burial 2 🗌 Cremation 3 🗍 6 4 🗍 Donation 5 🗍 Other (Specify)	Removal from State	lington	atory or other place Nat. Ce	m. 6/11	1/12 A	rlingto	ty or Town, State n, Virginia
permit Depart Impor any in		21. Signatura Funeral Syrvice License	4	6	Name and Addres	s of FacilitGeor Hill Rd.	ge P. Kal Oxon Hil	as Fune 1. Marv	ral Home PA land 20745
Physician/ Medical Examiner		23a. Enter the disease, or complete shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ications that caused the deat e cause on each line. a. Due to (or as a consequence)	th. Do not enter	the mode of dying		r respiratory arrest,		Approximate
9 ja 9	cal Examiner	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)	,					
requires that the death certificate be been signed by the attending physic should be detached for use as the br	Physician/Medica	IE EEMALE:	3c. If yes, outcome of pregna 1  Live Birth 2 Fete 4  Pregnant at time of 6	al death 3 🔲	Ectopic pregnanc: Other (specify)	у		23d. Date o	r e
requires that the des been signed by the a should be detached	۾	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the ur	derlying cause giv	en in Part I.	23e. Did tobac	1/	te to the cause of death?
sician; The law res certificate has be lirector, page 2 sho	Completed						24a. Was an autopsy performe	d? prio	re autopsy findings available r to completion of cause of th?
Physician: T this certifica eral director, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:		Othe	ace of Death (Check			
2 .8 0	cate: To	27. Manner of Death  1xxNatural 5 Pending	1  Inpatient 2  28a. Date of injury (Month, Day, Year)	ER/Outpatient 28b. Time of injury	28c. Injury	4 □ Nursing Hot	me 5 Residence 28d. Describe how		Specify)
_ ~ _ 0	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify				28f. Location (Stree City or Town, S		r Rural Route Number,
he Hospit in 24 hour he Funera pletely fills	Medical	(Check 2 Medical Example	cian: To the best of my know er: On the basis of examination	n and/or investig	gation, in my opinio	n, death occurred at	the time, date and o	lace, and due to	the cause(s) and manner stated.
Tot with Total		29b. Signature and title of conflict			29c. License				fonth, Day, Year)
240		30. Name and address of person who co	mpleted gause of death (Item	1 23a) (Type, Pr	IVINA P	en/S#	(US FT)	the ha	DUMD 2074
State Registra	-	31. Date filed (Worth, Day, Year) MAY 2 2 2012	32. Registrar's Signa	ture	es of some		1.00		0

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 19 Day Physician/ MAY 2012 ALBERT BROMWELL CHARLES 11:06 a™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Month, Day 1 XM 2 - F Months Days Hours 1916 Pennsylvania 95 June Director 165-10-0405 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 🗆 Yes 2 🕱 No Earleville MD Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral U.S.A. 21919 430 Hazelmoor Dr. 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 → Yes 2 → No 1941
If Yes, Give
Year or Dates. -1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Self-employed General Contractor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Ann Dixon Charles Bromwell permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any Injury or other traumatic s Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Hazelmoor Dr. Earleville, MD. 21919 Charles A. Bromwell, Jr. (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Kent Cremation Services 20c. Location - City or Town, State 20a. Method of Disposition ∠ Cremation 3 ☐ Removal from State 1 Burial 5/21/12 Smyrna, DE. 4 Donation 5 Other Specify 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 21. Signature of F M00510 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or an indition CONGESTIVE HEART FAILURE Pnysician Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the buri Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed autopsy death? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **%** No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12 MD 00062140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAW MD HERMAN HWY HUGUSTINE ISUITE A CHESAPEAKE CITY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alfred N. Birck 0945 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SalisburgRehabilitation Wicomico 4Nursing C Spura 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 → M 2 → F Funeral Min. 725-10-2026 Months Days Hours (Month, Day, Year) 05/04/1929 83 Director Montana Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Maryland Wicomico Delmar 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral or items 23a 8719 Lynch Drive 21875 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 K Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ð 1 Never Married 2 Married Alfred Birck Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Army "natural", Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Police Officer Law Enforcement Be permit. Page 1 and 2 should be filed vepartment of Health and Mental Hyg Important: If item 27 is marked oth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Inez Moore Phillip Birck injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Birck/Wife 8719 Lynch Dr., Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/23/2012 Salisbury Crematory 4 Donation 5 Other (Specify) Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ bzheimer > disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of,: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

When I have a first death.

Completed Director: After this certificate has been signed by the attending physician and completed filed in by the innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Yes g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one address of person who completed cause of death (Item 23a) (Type, Print 18 Borodu 31. Date filed (Month, Day, Year) Registrar's Signature State 4 2012 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of	of Maryla	_	artment of H tificate of L		and N	/lental Hy		2 [	112	18	268
	н	1. Decedent's Name (First, Middle	. ,		2 001	tinoate or E	Jean		2. Date of De	Reg. No.			3. Time of [	Death
Physicia Medic		Wilhelmena Jol	nnson Ball	Lou		_			Month <b>May</b>	Day 18	3 2	Year 2012	6:49	
Examin	er	4a. Facility Name (if not institution	, give street and nun	nber)		4b. City, Town, or	r Location of	of Death		4c.	County	of Death		
Funeral		602 Ray Drive 5. Social Security Number	6. Sex	7. Age (In vrs	last birthday)	Silver If Under 1 Year			8. Date of Bir		ontgo	omery	- O4-4-	E
Director		249-58-1295	1 □ M 2 🛣 F	78		Months Days	Hours	Min.	(Month, Da	ay, Year) /1933	3	Countr	ace (State or y) <b>Carol</b>	-
d d		Usual Residence of Decedent  10a. State 10b. County		140- 6					11101	1175.				
arylan a-f sh fied a	Director				City, Town or Loc							10	d. Inside City	
or 28	ă	Maryland   Montg 10e. Street and Number	omery	Si	lver Sp	10f. Zip Code				10a Citi	izen of W	hat Count		Z LI NO
s 23a	Funeral	602 Ray Driv	e			20910				US			, -	
death r item ner m		11. Marital Status	12. Was Dece		J.S. 13. V	/as Decedent of Hi Yes, specify Cuba	ispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race	- America		
after after all, or	d b	1 ☐ Never Married 2 ♣ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 Tes If Yes, Giv	<sup>2</sup> XNo		☐ Yes 2 🛣 No		,	,			k, White, et <b>Black</b>		
21215-0036 within 72 hours after glene. er than "natural", o t, the Medical Exam	Completed	15. Decede	nt's Education	ites.	16a. Deced	ent's Usual Occup	ation	_				siness Indu		
215 Din 72 De. han "	E I	(Specify only higher Elementary/Seconday (0-12)	est grade completed) College (1	-4 or 5+)	(Give k	ind of work done of NOT use retired)	during most	of worki	ing	102.74		3.11033 11100	ou y	
d with	o l	17. E-4b-ul- N2 (Eine N4)-d-1	<u>5</u> +		Specia	1 Educat					ucat		_	
anc be file antal H ked o c eve	ᆲ	17. Father's Name (First, Middle, L	•						e (First, Middle,	Maiden S	Surname)			
Maryland 2 should be filed lith and Mental Hy 27 is marked oth	ŀ	George Johnson  19a. Informant's Name/Relationsl			19b Mailin	g Address (Street a			Vilson   Route Numbe	er City or	Town St	ate Zin Co	ude)	
d 2 sh d 2 sh a alth a n 27 is er trai		Matthew Ballou	/Son			Montague							ide)	
of He		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	2 Demoved from		Place of Dispos	sition (Name of atory or other plac	e)		Date	20c. Lo	cation - 0	City or Tow	n, State	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (S	Specify)		aryland	National	5		/2012	Lauı				
Bal permir Depar Impor any ir	-	21. Signature of Funeral Service L	icensee			Name and Addres								
	$\dashv$	23a. Part 1. Enter the disease, or	complications that of	aused the dea		100 Georg					ning		DC ZUU Approximate	12
~ Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on ea	ch line.		Cancer							nterval Between Driet and De	
Medical Examiner		resulting in death)	a. Due to (	or as a consec	quence of	ONICES						+		
	<u>ا</u> و	Sequentially list conditions,	b. —									$\perp$		
B D	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (	or as a consec	quence of):							7.1		
be executed sician and burial (	Exa	that initiated events resulting in death) Last	c. Due to (	or as a consec	quence of):						_	_		
68760 certificate be executed adding physician and use as the burial car.	edical		d											
687 sertificat iding ph		IF FEMALE:	20-11											
BOX ( death ce he attend ed for us	cian	23b. Was decedent pregnant in the past 12 months?		come of pregn Birth 2  Fe nant at time of	tal death 3 🗌	Ectopic pregnance Other (specify)	у			2	23d. Date Mon	of delivery	/ lay Yea	ar
ords, P.O. Box 68  requires that the death certific been signed by the attending Ishould be detached for use as	by Physician/Me	1 ☐ Yes 2' No g ☐ Unknown	g Unkn		dealii 5 🗆	Other (specify)					WOII	01 0	dy 166	al .
that the med by e detail	oy P	Part II. Other significant condition	ns contributing to de	eath but not re	sulting in the ur	derlying cause giv	en in Part I.		23e. Did to	obacco us	se contrib	oute to the	cause of dea	ith?
dS,	ted					_			1 🗆	Yes 2	□ No 3	B 🗌 Proba	bly 4 Un	iknown
law re las be	Completed						-		24a. Was autor		24b. W	ere autops ior to com	y findings ava	ailable ise of
HA6									1 Perfo	rmed? 2 No		eath?	M No	
siciar certificacto	n	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		1	Otho	r:							- (1
Of \ g Phy er this ieral d	9 6:	27. Manner of Death	28a. Date	of injury	ER/Outpatient 28b. Time of	3 LJ DOA 28c. Injury	_4 🗀 Nu		me 5 Resid					
ending sath. or: Aft	ica I	1 Natural 5 Pendin 2 Accident Investig	ation	h, Day, Year)	injury	work	? Yes 2 🗆			,				
UNISION Of VItal RECORDS, isl or Attending Physician: The law requires staffer death.  Indirector: After this certificate has been signed in by the funeral director, page 2 should be an incomplete the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Could at 4 ☐ Homicide determine	ned 28e. Place	of Injury - At h		et, factory, office		2	28f. Location (S City or Tow		Number	or Rural R	oute Number,	$\overline{}$
pital ours a ours a filled i		29a. Certifier 1 **Certifying	Physician, To the he	act of my know	ulodeo doeth o	ours of shifts a bloss		1000						
DIVISION Of VItal Records, P.O.  To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the Completed filled in by the funeral director, page 2 should be detach	Medical	(Check 2 L Medical E	Physician: To the be xaminer: On the basi Nurse Practioner: 1	s of examination	on and/or investi	ation, in my opinior	<ul> <li>death occ</li> </ul>	curred at a	the time date a	nd place a	and due t	n the cause	e(s) and manne	er stated.
To the To		29b. Signature and title of certifier				29c. License		protoc				Month, Da		
		186	08			D	371	42	-	5.	23	-20	51	
	- [	30. Name and address of person v	i				12.		ville					$\neg$
State	3	G. Coleman V 31. Date filed (Month, Day, Year)	62. Re	egistrar's Sign	iccard	Dr	1-6	CKI	11116	MI	7			
Registra		MAY 23 20	12 Sent	w B.	par									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2012 24 8:32 p Cotherina Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Hagerstown Washington 314 Central Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Months 220-28-7705 78 Director 1 □ M 2 🛣 F Usual Residence of Deceden 09/08/1933 Maryland 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director notified 1 X Yes 2 No Hagerstown Maryland Washington 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? items 23a or ner must be n o Funeral 21740 U.S.A. 726 Maryland Ave 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 Widowed 4 K Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nt of Health and Mental Hygiene.
t: If item 27 is marked other than
or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sterilization Tech Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ N/A Edith Elizabeth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Central Ave Hagerstown, Maryland 21740 Powell / Daughter <u>Karin</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 05/28/2012 | Smithsburg Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel Signatu Funeral Service Li 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (0 disease or condition 100 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injur that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death be detached g 🗌 Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 0 medical meck istrar's Signature 31. Date filed (Month 32. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05/22 2012 10:00 David Burton Bickers Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital 9. Birthplace (State or Foreign Country) VA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** 1 🗓 M 2 🗆 F 03/23/1922 577-28-4870 90 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 No Huntingtown Calvert 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. Funeral 20639 5070 Sheckles Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ģ 1 Never Married 2 TM Married XYes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates. WWII 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene.

7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) NASA Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Payne Ernest C. Bickers, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 570 Carla Drive, Huntingtown, MD 20639 Pamela Hager/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 05/25/2012 Clinton, MD Lee Crematory 4 Donation 5 Other (Specify) Signature of Funeral Sovice Lipense 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 Lisa Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL ₽nysician/ HOUR disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live Sirth 2 Pregnant at time of death in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No s been signed by the same should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nunknown Division of Vital Records, VASCULAR DISEASE PERIPHERAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Hospital or Attending Physician: The l 24 hours after death. Funeral Director: Affer this certificate h 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 I DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 X Natural injury 5 Pending Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar

5

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

110

HOSPITAL RD. PRINCE FREDERICK, NO 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

WISN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State Amend #7 & 8,	e of Maryland / D 5/30/2012, R	epartment of F	lealth and Men HCHD, al	tal Hygier	ne 2012	18271
	Physicia	an/	Decedent's Name (First, Middle, Last)			2. 🛭	Date of Death		3. Time of Death
and the same	Medic	cal	Theodore A. Bork  4a. Facility Name (if not institution, give street and	number			lay 23	201 <u>2</u> 201	4:00 p <sup>M</sup>
i	Examir	ier	10038 The Mending Wal:			Location of Death		4c. County of Deat	_
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho			Date of Birth	9. Birt	hplace (State or Foreign intry)
	Director		Usual Residence of Decedent  123-26-8374  Usual Residence of Decedent	83 <u>81.</u> Yr		06	948/46	[928] S	NY
	land show	tor	10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	e Mary 28a-1 notifie	Director	MD Howard	(	Columbia				1 Yes 2 No
	vith the 23a or st be a		100.30 mb - No. 2.		10f. Zip Code		109.	Citizen of What Co	•
	eath v tems er mu	Funeral	10038 The Mending Wa	Decedent Ever in U.S.		spanic Origin? (Specify Y		United S-	
36	after d ", or i	Š	1 Never Married 2 Married	d Forces? Yes 2 No 1951-	If Yes, specify Cubar  1 ☐ Yes 2 🛣 No	n, Mexican, Puerto Rican	, etc.)	Black, White	e, etc.
21215-0036	atural	Completed		r Dates. 1953	ecedent's Usual Occupa				White
215	n 72 h e. ian "n Medi	dmo	(Specify only highest grade comple	ted) (G	ecedent's Osdar Occupa Give kind of work done di E. DO NOT use retired)		[ 16b	. Kind of Business/	ndustry
21	d withi lygiene her th	Be Co		5+	Architect			Building	g Industry
Maryland	be filed antal H ked ot c ever	To B	17. Father's Name (First, Middle, Last)  Theodore M. Bork			18. Mother's Name (Firs		•	
anyl	hould and Me s mar umati		19a. Informant's Name/Relationship (Type, Print)	19b. N	Nailing Address (Street a.	nd Number or Rural Rou			Code)
Σ,	and 2 s lealth a m 27 i		Wilma Bork - Wife	10	038 The Men	ding Wall	Columbi	a, MD 2	1044
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State cemetery,	isposition (Name of crematory or other place t Crematory			Location - City or Hanover,	
Balti	permit. Departr Importa any inju		21. Signet re of Funeral Service Licensee		22. Name and Address	s of FacilityHarry olumbia Pik	H. Witz	ke's Fami	lly FH Inc.
			23a. Part J. Enter the disease, or complications the shock, or heart failure. List only one cause of	nat caused the death. Do not				020/	Approximate
	nysician/ Medical		Immediate Cause (Final disease or condition a	to (or as a consequence of):	LATERAL	Scherosis			Interval Between Onset and Death
100 mg	Examiner	L	Secretaria de la composición del la composición del composición de la composición de la composición del composición del composición de la composición del la composición del composición d	to (or as a consequence of).					
	git d	Examiner	cause. Enter Underlying	to (or as a consequence of):		· · · · · · · · · · · · · · · · · · ·			
	and and II-trans	Exan	Cause (Disease or injury that initiated events c. Due	to (or as a consequence of):					
09	ate be executed bhysician and the burial-transit	dical	d						
876	tificate ng ph) e as th	Med	IF FEMALE:						
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  The Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnancy ive Birth 2  Fetal death regnant at time of death	3	,		23d. Date of deli Month	very Day Year
0	at the d by th	Phy	9 Unknown 9 Unknown  Part II. Other significant conditions contributing to		ne underlying cause give	en in Part I	23e Did tobacc	o use contribute to	the cause of death?
S, F	uires the signer of signer	Completed by	*	HYPERLIDER					bably 4 🗆 Unknown
Sord	w requests peers 2 should be seen a shou	plet	RHEUMATICA		,	2	24a. Was an	24b. Were auto	opsy findings available
Rec	<b>nysician:</b> The law nis certificate has b I director, page 2 s	Com				1	autopsy performeda I  Yes 2	death?	ompletion of cause of
ţ	ician: certific rector,	Be	25. Was case referred to medical examiner?			ce of Death (Check only			
) t	y Phys er this eral di	e: 10	27. Manner of Death 28a. Di	Inpatient 2 ER/Outpate of injury 28b. Tim		4 Nursing Home 5	Residence lescribe how inj		y)
ouo	ending sath. or; Afte he fun	ficat	2 Accident Investigation	fonth, Day, Year) inju	y work?		occide now my	ory occurred	
Division of Vital Records,	al or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Pla	ace of Injury - At home, farm, ilding, etc. (Specify)	street, factory, office		ocation (Street a ity or Town, Sta	and Number or Rura te)	al Route Number,
	e Hospit n 24 hour e Funera detely fille	Medical	29a. Certifier (Check only one) Certifying Physician: To the Check only one) Certifying Nurse Practitio	basis of examination and/or in	vestigation, in my opinion	death occurred at the tin	ne date and pla	ce and due to the c:	suse(s) and mannar stated
	To th To th COTE		29b. Signature and file of certifier	The state of the s	29c. License	number	29d. E	Date signed (Month,	Day, Year)
			1 Home wo			296	M	AY 24,	2012
1	ł		30. Name and address of person who completed of Juseph F G18Bows, M	1) 8186 LARK	BREWNRD, S	wine 201, El	KZIDGE	MA Z	7501
**************************************	Stat Registra		95 6 M O M O O S O I	Megistrar's Signature	parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Francis Beckley 1:10 P M 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Gilchrist Hospice Columbia 8. Date of Birth (Month, Day, Year) June 27, 1912 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 056-07-6870 Director 1 X M 2 🗆 F New York 99 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits at Director or 28a-f she notified Columbia 1 Yes 2 XNo Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral within 72 hours after death with 21045 United States 7070 Cradle Rock Way Apt 419 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black White etc. by i 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Longshoreman Shipping Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Kellerman Julia Christopher F. Beckley t. Page 1 and 2 should be tment of Health and Mer tant: If item 27 is mark jury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6049 Misty Arch Run Columbia, Maryland 21044 Janet E. Doyle/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of Important: If it any injury or conce. ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Svc. 5/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signa ure f Funeral Service Li 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerofic Cardiovase Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine ri any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 9 Unknown g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 4 POTENSION Yes 2 No 1 Yes 2 No Was case referred to medical Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🗌 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after com...

To the Funeral Director: After 1 Natural M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 00060632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

6336

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pay May 2012 Dortico L. Crawford Jr 1715 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 8 **Funeral** 9. Birthplace (State or Foreign Days Hours Min 216-27-2740 1 X M 2 □ F Maryland **Director** 1990 22 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 Clay St. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1X Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) 11th College (1-4 or 5+) the None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Dortico L. Crawford Sr Traleane D. Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Traleane Crawford (Mother) 116 Clay St. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial 5-22-12 Annapolis, Md. Gardens 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Almame a Recessor Facility Sons Mortuary, Lavy 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 00 Medical or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Exami that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the at 1 Yes 2 L 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify, မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5  $\square$  Pending injury work? 24 hours after death Funeral Director A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 **To the** I 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type)

State

Registrar

31. Date filed (Month, Day, Year,

MAY 22 2012

32. Registrar's Signature

			Plea									II Copie		_	ible.		
		For State		51	ate of N	/iaryian		artmen <i>rtificate</i>			and iv	lental Hy		20	112	1.8	271
		Registrar  1. Decedent's Name	(First, Middle	e, Last)				imoate	- 0, 5	outri		2. Date of De			116	3. Time of	Death
Physicia Medic		GERTRUDI	E CRE	W								MAY MAY	20 <sup>Da</sup>	<sup>ay</sup> 201	12 Year	6:02	а м
Examin	er	4a. Facility Name (if r		-				4b. City,						County	of Death		
Funeral		Chester  5. Social Security Nu		6. Sex		ige (In yrs. la	ast birthday)	If Under		rtowr If Under		8. Date of Bi	rth	Kent	9. Birthp	ace (State or	r Foreian
Director		220-14-31		1 □ M		85	Yrs.	Months	Days	Hours	Min.	(Month, D	1, Year)	26	Count <b>Mar</b>	yland	
how at	ř	Usual Residence of I 10a. State	Decedent 10b. County			10c. Cit	y, Town or Lo	cation							110	d. Inside Cit	v Limits
farylar Ba-f s tified	Director	MD	Quee	n Anne	e's	Che	esterto	own								1 🗆 Yes	-
a or 2 be no	i D E	10e. Street and Num	ber			-		10f. Zip					10g. C	itizen of W	/hat Coun	ry?	
th with ms 23	Funeral	401 Pear	r Tree						620			15.14	U.S				
or iter	by Fu	<ol> <li>11. Marital Status</li> <li>1 ☐ Never Marrie</li> </ol>	ed 2 😾 Mar	A	/as Deceden rmed Forces Yes 2	?		Was Deced If Yes, speci	ent of His fy Cubar	spanic Ori n, Mexicai	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	-		e - America k, White, e		
ırs aftı ural", I Exar	ted k	3 D Widowed 4		. If	Yes, Give ear or Dates.	• * * * * * * * * * * * * * * * * * * *		1 Yes 2	No No	Specify.	:			Specify:		White	
72 hou "nat	Completed	(Spec	15. Decede cify only highe	nt's Educations est grade con			(Give	dent's Usua kind of won O NOT use	k done di	ation <i>uring m</i> os	t of work	ing	16b. I	Kind of Bu	siness Ind	ustry	
within giene. er thau the N		Elementary/Seco 12	nday (0-12)	C	ollege (1-4 o	r 5+)		nemake	,					Own	Home		
filed tal Hyg	To Be	17. Father's Name (F		•								e (First, Middle	, Maiden	Surname	)		
uld be d Men marke natic	۴	David Ba			t4\							Winner					
12 shouth and the sho		19a. Informant's Nar David Ci			son)			-				Bear, 1				ode)	
1 and of Hea of item other		20a. Method of Dispo	osition				Place of Dispo	sition (Nam	e of			Date			City or To	vn, State	
Page ment tant: It		1 🔀 Burial 2 🗆 4 🔲 Dopation	☐ Cremation 5 ☐ Other (S	3 □ Remo	val from Sta		cill Po				5/23	/12	St	ill I	Pond,	MD.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fun	eral Service	Toencee/	/ /	·		2. Name and Galena	Fur	neral	. Hom	e of S	teph	en L.	. Sch	aech	
	Н						0 1 '	118 We	est (	ross	:St.	Galena or respiratory a	<b>∍,</b> M	D. 21	1635	Approximate	
Physician/		shock, or heart Immediate Cause (F disease or condition	inal	only one cau	1 1		Arre								,	Interval Bety Onset and D	eath
Medical Examiner		resulting in death)	"	a. —	Due to (or a	s a consequ	uence of):								-	) 17017V.	<u> </u>
	er	Sequentially list con if any, leading to imr	nditions,	b. —	Due to (or a		ory fr	21/41	re							yea	5
rted d insit	Examiner	cause. Enter Underl Cause (Disease or ii	lying injury		Duc to (or a	o a consequ	201100 01).										
(a) H (c)		that initiated events resulting in death) L		C. —	Due to (or a	s a consequ	uence of):										-
cate be executed physician and s the burial-transit	Physician/Medical			d											_	_	
leath certifica e attending pl d for use as t	n/Me	IF FEMALE: 23b. Was decedent p	oregnant		yes, outcom			_						23d. Dat	e of delive	rv	
death le atter	sicia	in the past 12 m 1  Yes 2	nonths?	4	☐ Live Birth☐ Pregnant☐ Unknown	at time of o	ldeath 3 L death 5 L	☐ Ectopic p☐ Other (sp		У				Mor			'ear
at the d by the etache		g Unknown Part II. Other signific	cant condition				ulting in the u	ınderlyina c	ause nive	en in Part	1	220 Did	tobacco	usa contri	bute to the	e cause of de	agth?
sician: The law requires that the death certificate has been signed by the atterector, page 2 should be detached for	Completed by	Pulmon														ably 4□ L	
w requ	olete	Drutyp										24a. Was				sy findings a	
The lay ate has page 2	Som	J										auto perf 1  Yes	ormed?		rior to con leath?	npletion of ca 2 🗌 No	luse of
cian: ertifica ector, I	Be	25. Was case referred examiner?		Hospit	al·				-		th (Check	only one)					
Physi rthis o	는 1	1 Yes 242 27. Manner of Death			1 Inpa		ER/Outpatier		Other	4 ⊔ N		me 5 Res					
inding ath. r: Afte ie fune	icate	1 ♥ Natural 2 ☐ Accident	5 Pendir	gation	(Month, E	lay, Year)	injury	м	work?			Edd. Doddilbo	now mju	y occurre	u		
or Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ			njury - At ho etc. (Specify	me, farm, str	eet, factory,	office			28f, Location ( City or To			r or Rural i	Route Numbe	ər,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burners.		29a. Certifier 1	Cortifying	Physician	To the best	of my knowl	edge death	occured at t	ha tima	data and	place an	d due to the ca	auco(c) a	nd manne	r ac etator		
ne Hos in 24 h ne Fun pleted	Medical	(Check 2	Medical B	xaminer: O	n the basis of	examination	and/or inves	tigation, in n	ny opinior	n, death o	ccurred at	the time, date e, and due to the	and place	e, and due	to the cau	se(s) and mar	ner stated
Within Com	_ ;	29b. Signature and ti	itle of certifie					900	License					1	(Month, D		
4			806	DAL)	)		\		00	55c	99	6	5	121	20/	2_	
M =		30. Name and address Neil Sto				death (Item		chest	erto	ייי או מייייים או	ר ת	1620		•			
M 5 Stat	e	31. Date filed (Month	, Day, Year)	4 004	32. Regi	rar's Signat	ture <b>B</b> .	back		MTT I	<i>v.</i> 2	1020					
Registra	ar		MAY 2	1 201	K Ja	neur	10.	7									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KIVEr Hospital town Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours 454-20-3173 Director 1 M 2X F 92 11/9/1919 Texas or 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 🙀 Yes 2 □ No Queen Anne's MD Centreville 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 01 Fieldcroft Way 21617 USA items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates "natural", Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 3 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tomas saenz Trinidad Reyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary S. Conti/Daughter 101 Fieldcroft Way Centreville, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State 05/17/12 Dover, DE Cremation, 4 ☐ Donation 5 ☐ Other (Specify) ionature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 717 W. Division ST Dover, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ardia C 44 Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 2 Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10065591 0-13-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21620 11 5

State Registrar ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2

		1	For State Registrar		State of	Mar ylai i		tificate of L		u Mentan ny	Reg. No.	OIL	10210
			1. Decedent's Name							2. Date of De		Year	3. Time of Death
	Physicia Medic	al _	Barbara I							May		2012	11:25pm
1	Examin	er 4	la. Facility Name (if I					4b. City, Town, or Rockvi		eath		ity of Death	.,
			Shady Gro			Spital 7. Age (In yrs. Ia	st hirthday)	If Under 1 Year	I If Under 24 F	rs. 8. Date of Bi		<del></del>	place (State or Foreign
	Funeral Director	ľ	172-34-37	1	1 M 2 X F	70	Yrs.	Months Days	Hours N	12-03-	ay, Year)	Cour	
			Usual Residence o	f Decedent						12-03-	-1741	1	_
	/land f sho ed at	햦	10a. State	10b. County		1	, Town or Lo						10d. Inside City Limits 1  ✓ Yes 2   No
	Man 28a- notifie	Director	MD	Montgor	nery	Roc	kville	10f, Zip Code			10g, Citizen o	of What Cour	
	ith the	밀	10e. Street and Num					20850			0	d Sta	
	ath w	Funeral	299 Hurle	ey Ave		dent Ever in U.S	i. 13. V		ispanic Origin?	(Specify Yes or No uerto Rican, etc.)		ace - Americ	can Indian,
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Marri		Armed Ford  1  Yes If Yes, Give Year or Date	2 🔀 No		f Yes, specify Cuba		uerto Rican, etc.)	Spec	lack, White, ify: Wh	etc. ite
2-0	hour "natu	Completed	(Spe	15. Decedent's	Education grade completed)		(Give	lent's Usual Occup	ation during most of	working	16b. Kind of	Business/Ir	ndustry
2	within 72 glene. ler than '	mo.	Elementary/Seco		College (1-	4 or 5+)	life. D	O NOT use retired) emaker			Own	Home	
2	led within Hyglene. other thai ent, the N	an F	17. Father's Name (F	First Middle, Las	<u></u>		1101116	шакет	18. Mother's	Name (First, Middle			
an	uld be file Mental narked c natic eve	입	Edward E							a Victori			
ary	1 and 2 should be file f Health and Mental I item 27 is marked c other traumatic eve		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number o	Rural Route Numb	er, City or Town	, State, Zip	Code)
Ž	N = 21 =		Joyce G1	oeckler	/Daughter		2932	Dubarry	Lane,	Brookevil			
Baltimore,	Page 1 and into the line of Healt into the line of Healt into other into or other				Removal from	CAMA C	emeterv. crer	esition (Name of matory or other place <b>Heaven</b>	oe) 05	Date 5/24/2012	Silve:		iown, State Lng, MD
Balti	permit. Page 1 a Department of B Important; If it any injury or of once.		21. Signature of Fur	neral Service Lic	ensee	м009				hibadeau thersburg			vice, P.A.
	W. O		23a. Part 1. Inter t shock, or heal Immediate Cause (	rt failure. List on	omplications that c ly one cause on eac	aused the deat				diac or respiratory a			Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)		a	or as a consequ	uence of):	· · · · · · · · · · · · · · · · · · ·					
		ē	Sequentially list co	nditions,	b. Justo i	or as a consul	ience of	- 0	0.				
	pg 10.	Examiner	cause. Enter Unde Cause (Disease or	II IJUTY	15	chen	10	Cali,	lis				
	icate be executed physician and is the burial-tage:	E I	that initiated event resulting in death)		Due to (	or as a consequ	uence of):	10 /	1	Faik	wat .		
09/	e be e	edical			d	Culi	Ke	Spirit	079	raix	COVE		
6876	ifficat g ph		IF FEMALE:		00 1/					-11/			
Box 6	To the Hospital or Attending Physician; The law requires that the dearh certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the ariending physician and completely filled in by the funeral director, page 2 should be detached for use, as the burial transfer.	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 ☑ g ☐ Unknown	months?	1 Live	nant at time of	aldeath 3	Ectopic pregnar Other (specify)	cy		1	Date of deli Month	Day Year
s, P.O.	requires that the been signed by should be deta	Completed by Pi	Part II. Other signif	ficant condition	s contributing to d	eath but not res	sulting in the	under ing cause g	iven in Part I.				the cause of death?
of Vital Records,	requipeen shoul	lete	Adv	on (PC	) De	acat				24a. Wa		b. Were aut	opsy findings available ompletion of cause of
ec	The law ate has page 2	mo M	-C/10+	/ (			-1-			_ pe	formed? s 2 🗶 No	death?	2  No
al F	ian; T rtifica ctor, p	Be C	25. Was case referr examiner?	red to medical						(Check only one)			
<u>Ş</u>	hysicia nis certi il direct	일	1 🗌 Yes 2	No No		Inpatient 2			4 L Nurs	ing Home 5 🗆 Re			fy)
1 0	ding Ph h. After th funeral	ate:	27. Manner of Deat 1 Natural	th 5 🗌 Pending	28a, Date (Mon	of injury th, Day, Year)	28b. Time o injury	woi			how injury occ	curred	
sior	death death stor: A	Certificate:	2 Accident 3 Suicide	Investigation 6 Could n	ot be 28e Place	of Injury - At he	ome, farm, st	M 1 L			(Street and Nu	mber or Rur	al Route Number,
Division	after Direct		4 🗌 Homicide	determi	ned buildi	ng, etc. (Specif	y)	,,,			own, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Chook 5	Medical Fr	aminer: On the has	sis of examination	n and/or inve	stigation, in my opir	ion. death occu	ace, and due to the irred at the time, date and place, and due t	e and place, and	due to the c	ause(s) and manner stated.
	To the To the To the	2			1		- colonia	- 0			00   D		
			30. Name and add	ress of person w	ho completed caus	se of death (Iter	n 23a) (Type,	Print)	1).	0 0	P	1/0 1	102086
	C/-	10	SAYE! 31. Date filed (Mon		SAYYA	Registrar's Sign	>   0	Mole	nfar	1. /c	CLVII	11/10	
	Sta Registr		MA	v 23 20	12 2.	M. A.	400	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 28 2012 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hage 1570un Hageistour Washina OV 9. Birthola ce (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours ′2∏ F 69 Jan. 30, 1943 Ohio Director 185-34-2476 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland r 28a-f show notified at 10b. County Pennsy1-1 ☐ Yes 2 No Director vania Franklin Greencastle 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or death with "natural", or Items 23a 12170 Randy Drive 17225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation th and Mental Hygiene.

7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Freight/Transportation 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Lewis Clark <u>Mary Elizabeth Kendle</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau Carolyn Frances Baer Clark, wife 12170 Randy Drive, Greencastle, Pennsylvania

Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery June 1, 2012 Greencastle, PA 4 Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHarold M. Zimmerman & Son Funeral 2 . Signature of Fundral Anice Licen Home, 45 S. Carlisle St., Hagerstown, MD 23a. Par . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h an failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Caus (Final disease or condition resulting in death) **Physician** no /Medical Due to (or as a consequence of) 01 Examiner CA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

weral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 2 201 R12574 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) 14014 MLISh CRUP oncordia Siconani

DHMH 17 Rev 1/2001

State Registrar 31. Date filed Moni

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Roger Dudley Cook, May 12:25 P<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Lusby 11115 Little Cove Point Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 ₩ M 2 🗆 F Months Days Hours Director 256**–**54–8525 Georgia 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10a, State 10b. County Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 🖄 No Maryland Lusby Calvert 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? United States 20657 11115 Little Cove Point Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ※ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates.1954-1962 traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Nuclear Power Company Mechanic / Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bessie Ezell Ambrose Calhoun E. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11115 Little Cove Point Road, Lusby, mD 20657 Evelyn Mae Cook / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/24/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physicien Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To After this 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at atural 5 Pending work? 1 🔲 Yes 2 🗌 No Accident Suicide Investigation after death completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who cor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Levin H. Dennis, Jr. 00 7:02 Medical 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOM 100 MIGICAL REGIONAL SAUSBUL TONINSUM Social Security Number Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 214-32-7103 Director 1 🛛 M 2 🗆 F Yrs 75 2-1937 th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 XNo Pocomoke Worcester MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21851 1923 Pit Circle Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo ģ 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: sp Bildack If Yes, Give 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Daisey Schoolfield Levin H. Dennis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Health a Important: If item 27 is any injury or other tree 1923 Pit Circle Road, Pocomoke, MD 21851 <u> Oueen Dennis/Wife</u> 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Georgetown Bapt</u> 5-26-2012 Pocomoke, 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Signature of Funeral Service Licensee Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Throsekrotie Physician/ moditionsculer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physicien and I for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 2 🗷 No Certificate: To I 1 Yes 1 Inpatient 2 A ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Civic Ave Corodulia, Car 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State o	f Marylaı	nd / Depa				and M	lental Hy	giene	9	L //		000
			State Registrar				Cer	tificate	e of D	eath			Reg. No	<u>. 20</u>	2	_   8	1280
	Physicia	in/	Decedent's Name		· ·							2. Date of De Month	Da	av Y	ear	3. Time	of Death
	Medic	cal		nael Do								May 20	), [	2012 Y		11:1	5 pм
	Examir	ier	4a. Facility Name (if I	s Hospi		per)				Location Spr			40	. County of Mont		ery	
	Funeral		5. Social Security Nu			7. Age (In yrs.	last birthday)	If Under Months	r 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da		9	. Birthp	ace (State	or Foreign
	Director		464-51-95 Usual Residence o		1 XXM 2 □ F	3:	2 Yrs.					Dec. 22		79	II	* .	
	and show	5	10a. State	10b. County		10c. C	ity, Town or Lo	cation				-			10	d. Inside (	City Limits
	Maryl 28a-f otifiec	Director	MD	P.G.			Hyat	tsvil	.le							1 🗆 Ye	s 2X No
	a or 2		10e. Street and Num	ber		-		10f. Zip	Code				10g. Ci	tizen of Wha	t Count	ry?	
	th with ms 23 must	Funeral	5819 32n	d Avenue	1				2078				US	SA			
	r deal		11. Marital Status  1 🛣 Never Marrie	ad 0 🗆 Mamiad	12. Was Deced	ces?		Vas Deced Yes, spec	lent of His cify Cubar	spanic Ori n, Mexicar	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Black,			
21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Completed by	3 Widowed 4		1 ☐ Yes If Yes, Give Year or Da		1	X Yes	2 🗆 No	lexic	an/Gu	ıatemal	an	Specify: V			
2-0	hour natur dical	olete	(Snor	15. Decedent's cify only highest of	Education		16a. Deced	lent's Usua	al Occupa	tion				(ind of Busin	ess/Ind	ustry	
21	hin 72 ne. <b>than</b> ' <b>e M</b> e	E	Elementary/Secon		College (1-	4 or 5+)	life. Do	kind of wor O NOT use	retired)		ST OT WORKI	ng	- T	C		m1	. 1
7	s filed within 72 hours after death with the Maryland rat Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	O O	17. Father's Name (F				1.1	Tec						format	lon	recm	orogy
Maryland		70 E	Luis Do									(First, Middle, 1iralle		Surname)			
ary	2 should be th and Ment 27 is marke traumatic e		19a. Informant's Nar	me/Relationship	Type, Print)		19b. Mailin	g Address	(Street a		-	Route Numbe		Town, State	a, Zip Ci	ode)	
	O		-	uiz/Motl	ner		5819	32nd	Aven	ue,	Hyatı	sville	, N	1D 207	82		
ore	je 1 and 2 t of Healt If item 2 or other		20a. Method of Dispe		☐ Removal from :		Place of Disportant cemetery, crem	sition (Nan natory or o	ne of ther place	)	May	ate 24.	20c. Le	ocation - Cit	y or Tov	vn, State	
Baltimore,	it. Pag rtmen rtant: njury		4 Donation	5 Other (Spec	cify)		ropoli				May 20		_	xandri		VA	
Bal	permit. Page 1: Department of I Important: If it any injury or of		21. Signature o	eral Service Lice	7	<u> </u>						Funeral . W., S				, MD	20901
П			23a. Part 1. Enter th shock, or heart	e disease, or cor failure. List only	nplications that ca	aused the dea h line.	th. Do not ente	r the mode	e of dying	, such as	cardiac o	respiratory ar	rest,			Approxima Interval Be	
+	Physiciani'		Immediate Cause (F disease or condition		Sepsi										3	Onset and	Death
net.	Medical Examiner		resulting in death)	•		ras a conseq	patic E	naanl	holor	o+hr	7						
		Je.	Sequentially list con	ditions,	h —	ras a conse		псері	naroj	Jaciny							
	d ansit	Examiner	if any, leading to impose cause. Enter Underline Cause (Disease or in	njury	End-S	tage L	iver Di	.sease	e								
	exectan an an Irial-tr	EX	that initiated events resulting in death) La		Due to (c	r as a conseq	uence of):										
09	death certificate be executed re attending physician and ed for use as the burial-transit	dical			d												
587	ortifica ding p		IF FEMALE:		23c. If yes, outc	ome of progn	anou								+		
Box 687	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent p	onths?	1 Live E		al death 3 [	Ectopic p					Î	23d. Date o Month		y Day	Year
. B	the de by the ached	hysi	1 Yes 2 9 Unknown	INO	9 🗌 Unkno			. 0									
P.O.	that ined b	oy P	Part II. Other signific	cant conditions	contributing to de	ath but not res	sulting in the u	nderlying o	ause give	n in Part	I.	23e. Did to	bacco u	use contribu	e to the	cause of	death?
ds,	quires en sig ould b	Completed by										1 🗆 '	Yes 2	□ No 3[	Proba	ably 4 🔀	Unknown
cor	aw reas be	ple										24a. Was autop		24b. Wer	autops	sy findings	available cause of
Re	The la	Con										perfo	rmed?	deat			
tal	ician: sertific ector,	Be	25. Was case referred examiner?		Hospital:						th (Check	only one)					
Ę.	Physical chiral	<u>ا</u>	1 Yes 2 2 27. Manner of Death	No	1 🔯	· -	ER/Outpatien			4 ∐ Nι		ne 5 🗆 Resid			pecify)		
0 0	Attending Physician: r death. ector: After this certific by the funeral director,	cate	1 X Natural 2 Accident	5 Pending	(Month	, Day, Year)	injury	M	Bc. Injury : work? 1   V			8d. Describe h	ow injur	y occurred			
Division of Vital Records,	Atter er dea ector by th	Certificate:	3 Suicide	6 Could not	be 28e. Place o		ome, farm, stre				-	8f. Location (S			Rural F	Route Num	ber;
<u>≤</u>	tal or rs afte al Dir led in				building	g, etc. (Specif)	V)					City or Tow	n, State)	)			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the Completely filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 L	Medical Exan	ysician: To the be niner: On the basis	of examinatio	n and/or investi	gation, in n	ny opinion	, death oc	curred at t	he time, date a	nd place.	, and due to	the caus	e(s) and ma	anner stated.
	o the	Ž	only one) 3 L 29b. Signature and ti		rse Practitioner:	To the best of i	my knowledge,		Irred at the	_	te and plac			(s) and manr te signed (M			
	777				Zahn	-ani	an			5372				y 21,			
			30. Name and addres	ss of person who	completed cause	of death (Iten	n 23a) (Type, Pi	rint)	100	, , , , ,							
			Majid Rah		MD 15	00 For	est Gle	n Roa	ad, S	Silve	r Sp	ring, M	D 20	0910			
	Stat Registra	٠	31. Date filed (Month,	Day, Year) 23 201	2 Centre	gistrar's Signa	per	2									

2-04033	Please Type or Print in Black Indelible Ink. Ensure All Copies Are I	egible.	
onya Yolanda Davis	State of Maryland / Department of Health and Mental Hygiene		2012
1- For State Ragistrar	Certificate of Death	Reg. No.	2012

onya Yolanda	Dav	State of Maryland / Department of Health and Mental I  1- For State  Certificate of Death		20	12   828
Physici	an/	Ragistrar  1. Decedent's Name (First, Middle,Last)	2. Date of De	Reg. No. ath	3. Time of Death
∕ledical Exami		SONYA YOLANDA DAVIS	Month May 27, 2	Day Year 2012	2240 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of D	
		Shady Grove Adventist Hospital Rockville		Montgome	,
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24F Months Days Hours M	P	irth(MM/DD/YYYY) 9	preign
Director		226-08-5557 1 M 2XF 43 Yrs.	09/0.	1/1968	Country) DE
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
B . 1		MD Montgomery Germantown			1 X Yes 2 No
Aaryland 28a-f show 1 at once.	당	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
th the Maryland 23a ur 28a-f sho notified at once	Director	20206 Thunder Head Way 20874		USA	
with t	<u> </u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (			merican Indian, Black,
death r iten	nue	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, et	tc.
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: E	Black
hours natur	ъ	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b, Kind of Busine	ess/Industry
136 hin 72 ee.	plet	Elementary/Secondary (0-12) College (1-4 or 5+)		Davi Care	
5-00; led with Hygiene other t	Complete	12th Day Care Provider  17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle,	Day Care Maiden Surname)	:
21215-0036 uld be filed within 72 hos Mental Hygiene. marked other than "na	Be C	James Davis Mary P	arker	•	
	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of	r Rural Route Nu	mber, City or Town, S	State, Zip Code)
MD d 2 shoulth and in 27 is		Mary Davis/mother 20206 Thunder Head W			
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Realth and Important: If item 27 is religivy ar other traumatic.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - Cit	y or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: Argent Cremation Svc 05	31/201	2 Hanover	, MD
Balti permit Departn Imports				Funeral Ho	
		23a. Part I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac	St, Roc	kville, MI	
Physician Medical		failure. List only one cause on each line.	or respiratory ar	rest, snock, or neart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Cardiomyopathy  Due to (or as a consequence of):			Death
· 1		Sequentially list conditions,  b			
1.	miner	frany, leading to immediate cause. Enter Underlying Cause			
0	ami	Cutseadas or injury that indicated events resulting in death) Last vents resulting in death) Last vents resulting in death) Last vents resulting in death indicated events resulting in death) Last vents vents resulting in death vents v		-	
executed an and al - transit	I Exa	d.			
e exc	dical	■ MENDED ■ AMENDED 23a, pt.II, 27, per me, g928 6-19-	-12 sm		
	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of del	
Box 68760 e death certificate b the attending physical or use as the bu	Physician/Me	past 12 months?	nancy	Month	Day Year
Box 6 e death cer the attendi	ysic	1 Yes 2 No 9 V Unknown 9 Unknown		ì .	1
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1	tobacco use contribut	e to the cause of death?
es ig	d by	Hypertension; Morbid Obesity; Asthma	1 Ye	es 2 No 3	Probably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seen by the fineral director, page 2 should!	Completed		24a. Was		e autopsy findings available to completion of cause of
eco he law ate has	E		perfo 1 ✓ Yes	ormed? deat	h? Yes 2 No
Vital Rec ysician: The l his certificate l director, page	Be C	25. Was case referred to medical 26.Place of Death (Chec			
Vita bysici this ce	To B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2  ER/Outpatient 3 DOA  Other Nurs	sing Home 5	Residence 6 0	ther:
I Of ing Ph After funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
ttend death ctor: y the	atic	2 Accident Investigation			
Division pital or Atten ours after death ireal Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	28f. Location ( or Town,		r Rural Route Number, City
Division  To the Bospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide			
To the Hos within 24 h To the Fun completely	Medical	check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred			
To To com	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed	(Month, Day, Year)
		O.C.M.E.		May 28, 2012	
		30. Name and address of person who completed cause of death (Item 23a)		<u></u>	
		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore,	MD 21223		
	tate	31. Date filed (Month, Day, Year)			
Regis	trar	JUN 05 2012 Jenus B. A			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 8282 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anderson Daub Mayth Ruth 20 2012 3:44 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16016 Plumtree Lane Williamsport Washington Social Securify Number If Unde 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Nov.8, 1934 Maryland 218-30-9756 77 1 🗆 M 2 🗶 F Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16016 Plumtree Lane 21795 USA Was Deceue... Armed Forces? Ves 2 XXIIIo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2 No Specify. If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Owner Garage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Isaac Anderson May Warrenfeltz Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George D. Daub - Husband 16016 Plumtree Lane Williamsport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Greenlawn Mem. Park May 31, 2012 Williamsport, Maryland 4 Donation Other (Spec 22. Name and Address of Facility Osborne Funeral Home, P.A. of Fureral 21. Signat 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cetastale disease or condition resulting in death) Due to (or as a consequence of) Dancre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 1 Yes yper len Sin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 11 No Other: ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home

Medical **Examiner** burial-transi nding physician ause as the burial The law requires that the death certificate be P.O. Box 68760 atten for be detached the signed by Division of Vital Records, peen has page 2 funeral director,

**Funeral** 

**Director** 

show

28a-f

ō

death

ms 23a o must be

the Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Fyaminones.

Phui ian

Baltimore, Maryland 21215-0036

notified at

lospital or Attending Physician: 24 hours after death Funeral Director: A

27. Manner of Death

1 Natural

Accident

Suicide

4 Homicide

5 Pending

Investigation 6 Could not be

determined

Certificate:

To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)	ck 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state						
		29b. Signature a	nd title of certifier	lose MD	29c. License number 027898	29d. Date signed (Month, Day, Year)  5/2-4/1 2			
TN-10		30. Name and ac		mpleted cause of death (Item 23a) (Type DRADE 277	HILL ST. HAGER	2STOUN 4112(140			

egistrar's Signatu

28a. Date of injury (Month, Day, Year)

State Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05/164/2012 ar **Physician** 11:15рм Alice Elizbeth Everton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Adelphi Prince Georges Heartland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Mgnth, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs, last birthday) **Funeral** Days Hours 1 ☐ M 2 🖳 F 90 214-18-8497 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Completed by Funeral Director Prince Georges Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20706 6209 Princess Garden Pkwy USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unknown College (1-4or 5+) Housekeeping Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Unknown Alice Askins ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6209 Princess Garden Pkwy Lanham, MD 20702 Agnes Gaither-daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/23/12 Beltsville, MD 4 □ Donation 5 □ Other (Specify) Chesapeake 22. Name and Address of Facility W.H. Bacon Funeral Home 21. Signature of Funeral Service Licensee Wanda C. Bacon 3447 14th St., NW Washington, DC 20010 CC0361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYDCAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlainer resulting in death) Last Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗷 Nursing Home 5 🔲 Residence 6 🗎 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Completely filled in by 4 Homicide 29a, Certifier f 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7325A VICTOR edver 31. Date filed (Month, Day, Year) State 23 2012 Registrar

12-03831	1	2-	0383	31
----------	---	----	------	----

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bergen Dyer Fer		alt S	tate of Maryla	and / Depa		f Health an		l Hygiene	20	12 1828	
Physicia		Registrar 1. Decedent's Name (First, Midd	dle,Last)		Tuncate or	Deaui		2. Date of De		3. Time of Death	
Medical Examin								Month May 19,			
		4a. Facility Name (if not institution 302 Washington Stre	ion, give street and nur	mber)		4b. City, Town, or Salisbury	Location of De	eath	4c. County of De Wicomico	ath	
Funeral		5. Social Security Number		7. Age (In yrs. I	last birthday)	If Under 1 Yea	ar If Under 24	4Hrs. 8. Date of B	Birth (MM/DD/YYYY) 9.	Rirtholace (State or	
Director		·	1 X M 2 F	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	29 Yrs	Months Day		Min.	For	reign	
	ŀ	213-11-7641 Usual Residence of Decedent						MAKUI	1 19 <b>,</b> 198ß	COMARYLAND	
w any		10a. State 10b. County		10c. City	, Town or Locat	ion				10d. Inside City Limits	
yland a-f she f once	ito	MD WICOM 10e. Street and Number	ICO	SAL	ISBURY	10f. Zip Code			10g. Citizen of What C	1 Yes 2 X No	
he Mar or 28	Funeral Director		· contrep					1	-	·	
with the ns 23s	E	302 WASHINGTON  11. Marital Status	12. Was Dece	edent Ever in U				(Specify Yes or N		erican Indian, Black,	
or item	-un-	1 Never Married 2 M	1 Yes	2 X No		es, specify Cubar		erto Rican, etc.)	White, etc		
is after nral", miner	2	3 Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates:			Yes 2 X No			Specify: WH		
2 hour	Completed	Elementary/Secondary (0-12)				ost of working life			16b. Kind of Busines	s/Industry	
036 rithin 7 rar than	m D	12			LINEMAL	N			AIRLINE M	ANUFACTURING	
5-0 filed w Hygie dothe		17. Father's Name (First, Middle	, Last)				18.Mother's Na	ame (First, Middle,	Maiden Surname)		
21215-0036 vuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	JOHN DAVID FER 19a. Informant's Name/Relations			19b. Mailing				E BROWN SCO Imber, City or Town, Sta		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	-	BONNIE SCOTT /	MOTHER						STON, MARY		
re, l		20a. Method of Disposition  1 Burial 2 X Cremation			Place of Disposi crematory or oth	ition (Name of cer	metery,	Date	20c. Location - City		
Baltimore, permit. Pages i ar Department of Hec (mportant: If ite injury or other tr		4 Donation 5 Other S	pecify:	an oldlo	ESAPEAKI	E CREMAT	ION 05	5/21/2012	STEVENSVI	LLE, MARYLAN	
3alti ermit. Separtr mport		21/Signature of Funeral Service		•	Fen	ame end Address LLOWS, H	s of Facility ELFENBE	EIN & NEW	NAM FUNERA	L HOME, P.A.	
Physician	1	232. Part I /Enter the disease, or	complications that ca	used the death	1130	U SPEEK I	KUAD CH	IESTERTOW	N. MAKYLAN	D 21620 Approximate Interval	
/Medical	al Home List only one cause on each line.									Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Heroin Intoxication  Due to (or as a consequence of):									
	-B	Sequentially list conditions, if any, leading to immediate	b	consequence o	nf):						
		cause. Enter Underlying Cause (Discuss or injury that in Matx)									
uted d ansit	if any, leading to immediate cause. Enter Underlying Cause (Discusse or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  AMENDED 23a, 27, 28a-f, per me, g928 6-12-12 sm										
ox 68760, eath certificate be executed attending physician and for use as the burial - transiti											
760, icate by physic the burner	Me	IF FEMALE: 23b. Was decedent pregnant in th		utcome of pregr					23d. Date of delive	•	
Box 68760 e death certificate b the attending physical for use as the bu	Cian	past 12 months?	I L LIAG DII	rth ant at time of dea	ath -	taldeath 3 L ner <i>(Specify)</i>	Ectopic preg	gnancy	Month	Day Year	
Box e death the atte	Physician/Me		known g Unknow								
	P	Part II. Other significant conditi	ions contributing to	death but not re	esulting in the ur	nderlying cause g	iven in Part I.	23e. Did to	obacco use contribute t s 2 ✓ No 3 Pr	to the cause of death?	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rafter death.  In Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detacted.	ted							24a. Was		autopsy findings available	
COLC e law re e has be	Completed							autop	psy prior to pri <u>ed</u> ? death?	completion of cause of	
Vital Recysician: The I	٥	25. Was case referred to medical				26.Place	of Death (Che	1 Yes	2 No 1 V	Yes 2 No	
Vita hysician this cer	To Be	examiner? 1 ✓ Yes 2 No	(Hospital:	patient 2	ER/Outpatient	- Tr	Othor -		Residence 6 🗸 0th	er: Scene	
ing Ph After t		27. Manner of Death	28a. Date of (Month, D	f Injury Day,Year)	28b. Time of In	· ·   _ ·	y at Work?		how injury occurred		
Sior Attend r death ector: by the	Catio	⊟ Pend	stigation Id 5-	-19-12		pm	res 2 X No	unknown			
Divi	モー	3 Suicide 6 X Could 4 Homicide deter	Id not be rmined (Specify)			t, factory, office bu esidence	-	or Town, S	State) 302 Wash:	Rural Route Number, City ington St.	
Division of To the Hospital or Attending Phayihin 24 hours after death. To the Funeral Director: After temperal Director is the funeral Director of the Attent of the Atte		29a. Certifier 1 Certifying Ph	hysician: To the best	of my knowledg	ge, death occurr	ed at the time, da	ite and place, a	Salisbu and due to the caus	se(s) and manner as sta	ated.	
S T Wit	g	one) 2 Medical Exer	miner: On the basis of and manner sta	examination an	nd/or investigation	on, in my opinion,	, death occurre	d at the time, date	and place, and due to	the cause(s)	
	<b>E</b> 2	29b. Signature and title of certifie	///		_	29c. License			29d. Date signed (M	onth, Day, Year)	
	Ļ	30. Name and address of person	to an alorad wine	of death (Itam	22-1	O.C.N	/l.⊑. 		May 20, 2012		
OGME	1	Mary G. Ripple MD.	Deputy Chief Me	•		W. Baltimore	Street, Bal	Itimore, MD 21	1223		
Sta	_	31. Date filed (Month, Day, Year)	0 0 2012 Reg	istra s Signatur	re <b>Ø</b> . ;	barles					
Registra	ar –	[[] ]	4 60 4014	Leyen		/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Physician/ 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner API 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 89 102-16-1812 Director 1 M MXX F 4/25/1923 NY 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director MD Anne Arundel Annapolis 1 Yes XX No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21401 2016 Puritan Terrace items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XXXes 2 No WWII
If Yes, Give
Year or Dates. 9 þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XXIIo Specify: "natural", Specify 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Virginia Erlum Clarence E. Gurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21401 George Grisham Husband 2016 Puritan Terrace 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1XXBurial 2 Cremation 3 Removal from State Peter's Cemetery 5/30/12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facilit Hardesty Funeral Home, Date 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dualto (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed 2 🗀 No 2 👿 N 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 卢 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 🗌 No within 24 hours after death

To the Funeral Director; /
completely filled in by the Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 5/21/2012

State

DHMH 17 Rev 06-2011

Registrar

Erika Benns 139 Old Solomons Island Rd. Annapolis, MD 21401

aistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
MAY 22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Ε. Goslee 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MICOMICO Center 544136414 KEGIONAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours 226-06-4065 Director 1 🗌 M 2 💢 F 40 7-16-1971 Germany Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hartis Hygiene than the file and 27 is marked orther than "natural", or items 23a or 28a-1 show luny or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21830 6718 Oak Ridge Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 🏋 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Goslee. Marion Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6718 Oak Ridge Drive, Hebron, Maryland 21830 David Donaway - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury 5-25-2012 Hebron Cemetery Hebron, Maryland 21. Signature of Fungral Service Licens 22. Name and Address of Facility Bounds Funeral Home Ĕ E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ monny Medical resulting in death) Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ē Exami for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day ate has been signed by the a page 2 should be detached f 9 . Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Ø Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and page 2. autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 🔀 No 1 Yes 1 № Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 🗡 Natural 5 - Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) D.O 22 12 471890 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury

DHMH 17 Rev 06-2011

State Registrar Vie +

Woodbrocke

Da

MD

21804

1665

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Day 2012 Physician/ 21, Francis Thomas Gil1 1:40 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10502 Tenbrook Drive Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 88 Director 578-22-7540 1X M 2 D F April 4, 1924 Maryland Usual Residence of Decede or 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 XNo Silver Spring Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 10502 Tenbrook Drive 20901 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 2 1 Never Married 2 X Married Maryland 21215-0036 Specify:White 1 ☐ Yes 2 🕱 No Specify: If Yes, Give 3 Divorced Completed Year or Dates. WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Appliance Repairman Repair Service Be permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnâme) Carrie Katherine Caroline Stohlman John Henry Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha I. Gill/Wife 10502 Tenbrook Drive, Silver Spring, MD 20901 Baltimore, Date 24, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 2012 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Memorial Park 21. Signature of Aneral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician a. Aspiration Pneumonia disease or condition resulting in death) week Medical Due to (or as a consequence of) Examiner Parkinson's Disease yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Diabetes Mellitus, Type II 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Obesity page 2 autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗌 No Yes 2 □XN Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5  $\square$  Pending 1 🖺 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1006170 (D)

State Registrar Name and address of person who cor

31. Date filed (Month, Day, Year)

Mark V.

10005 Old Columbia Road, #170, Columbia, MD 21046

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD

Sivieri,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Marie Gladhill Donna 13:14  $p^M$ Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16901 Lakeview Court, Lot #310 Washington Hagerstown . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Davs Hours Min. 1 □ M 2 💢 F Director 9/8/1943 68 Yrs Maryland or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location death with the Maryland Director 1 Yes 2 No Hagerstown 10f. Zip Code MD Washington ö 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral 16901 Lakeview Court, Lot S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian Black, White, etc. P þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify. "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) Medica1 Ith and Mental Hygien 27 is marked other the r traumatic event, the Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o Donovan Moats Josephine McKee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jason Scott Gladhill / 460 Rivanna Run, Falling Waters, WV 25419 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/31/2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) awn Mem. Park Cedar 22. Name and Address of Facility Rest Haven Funeral Chapel Signature of Funeral Service E 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final tast Physician/ CUS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to lor as a consequence of if any leading to immedicause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Year Month Day 5 Other (specify) Pregnant at time of death Unknown 9 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page performed? death? 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျင 4 
Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) thin 24 hours a the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2 DOO 68995 ess of person who completed cause of death (Item 23a) (Type, Print) seistann, MD 21740 Yon9

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Martha Viola Gish 2012 9:344 May 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1217 Washington Salem Ave. Hagerstown 9. Birthplace (State or Foreign Country) Mary land 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** Hours (Month, Day, Year) 6/21/1918 Director 220-10-3278 1 □ M 2**X**] F 93 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1217 Salem Ave 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2X No "natural", or Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Shoe Manufacturing Shoe Inspector permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blanche Runkles Marshall J. Manspeaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21740 Janet Thompson / Friend 1437 Church St. Hagerstown, Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 Donation 5 Other (Specify) 05/29/2012 Hagerstown, Maryland Rest Haven Cemeterv of Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Salen Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events physician ar resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 as been signed by the attending I should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cau<sup>t</sup>se given in Par<u>t</u> 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed Were autopsy findings available prior to completion of cause of death? 34a. Was an Was an autopsy performed? has page 2 certificate 2 No ☐ Yes 2 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 💾 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 Pending Natural work 1 Yes 2 No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 027898 des 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTOWN MILL ST. ANDRADE nANCI34 Date filed (Month) 32. Begistrar's Signature State Registrar

Registrar
DHMH 17 Rev 7/2009

State

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month & Physician/ Hankerson Delores 148 PM Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death oastal S Dice at Wilomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 224-74-3278 Director 1 M 2 2 F 62 11/26/1949 Maryland Usual Residence of Deceden 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
I tem 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Mydical Examination must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7547 Brent Ave. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married ģ Yes 2 No Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 OTCS Catherine Belle Giddens James Edward Church Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 Is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7547 Brent Ave., Salisbury, MD 21801 Rufus Hankerson/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Borial 2 Cremation 3 Removal from State Parsons Cemetery 4 Donation 5 Other (Specify) 5/26/2012 Salisbury, MD Signature of Funeral S Stewart Funeral Home by Holloway and Downey, P.A. 821 West Rd., Salisbury, MD 21801 a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between lock, or heart failure. List only one Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ca Ovano Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To tha Hospital or Attanding Physiclan: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was de edent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death signed by the at Id be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ √Vo 1 ☐ Yes 2 ☐ Mo 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this c Other (Specify) Hospi 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred at the Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and where, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number D 63199 20/12 UTC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOHRA YOGESH 910 EASTERN SALISBURY MD 21844 SHOPE DR. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1333 PM our se Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Center Meritus Medical Washington Hagerstown Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏋 Months Hours Min Sept. 23 Director 1925Pennsylvania 174-20-8728 86 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14727 Pennsylvania Avenue 21742 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nelson Russell Leckron Lillian Celeste Byers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3354 Conococheague Lane, Greencastle, PA 17225 <u>Barry L. Hartle,</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beautiful View Cemetery 6/1/2012 Middleburg, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of FacilityHarold M. Zimmerman & Son Funeral Home, 45 South Carlisle St., Greencastle, PA 17225 23a. Part 1 Inner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician myocardial disease or condition Medical resulting in death) Examiner alleroscleration ortmany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? : After this certificate tuneral director, pag 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury in 24 hours after commune Funeral Director: Afternated filled in by the fur 1 Yes 2 🗌 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of contifier 29d. Date signed (Month. Dav. Year) M.D. MD03603

State Registrar Hagerstown

733

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fallam

Payam

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 201.2 Thomas Hunt Hardinge, Jr. May 7:15 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13253 Fountain Head Road Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) 217-16-2576 87 **Director** 1 **X**M 2 □ F 12/11/1924 Hagerstown, MD Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13253 Fountain Head Road 21742 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian rmed Forces?

XYes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 th Vice President Furniture Mfgr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hannah Gunnell Thomas Hunt Hardinge, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatin an Important: If item 27 is . Page 1 and 2 sl ment of Health a T. Hunt Hardinge III / Son 13313 Marquise Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 6/02/2012 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ and C atrice disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: signed by the attending be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 2 No 1 Yes To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certific ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec 3 Certifying Nurse Practition 7: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only o 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) JU-15+ 111 14150 State Registrar

DHMH 17 Rev 06-2011

Box 68760

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jean Bryant Hugg May 23, 11:26 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F 08/09/1928 Maryland **Director** 83 217-26-1791 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Solomons 5 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11740 Asbury Circle, Apt. #1408 20688 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian. Armed Forces or i Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: White "natural", 3 Divorced 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) House Wife Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Frances Payne Raymond C. Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11740 Asbury Circle, Apt. #1408, Solomons, MD 20688 John Alexander Hugg, Jr. Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 5/24/12 Alexandria, Virginia 4 Donation 5 Other (Specify) Rausch Funeral Home, P.A. 21. Signature of Funeral Service Lig 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examir Cause (Disease or iinjury that initiated events burial-tran resulting in death) Last physician Physician/Medical requires that the death certificate be Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death signed by the a g Unknown g Unknown P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autonsy certificate | 2 00 Yes 1 Yes Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital Yes 2 No ည npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Division of 27. Monner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural or Attending injury work? 5 Pending Accident Suicide Investigation 2 No To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of skamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practioner: To yie best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number Lew 5 State Registrar

	AMEN	D I	Please PI LINE A PER MD G	Type or Print in 929 7/5/12 TR State of Marylan	<b>Black Indel</b> Id / Departm	ible Ink. Ensure ent of Health and	<b>All Copies</b> Mental Hyg	Are Legible	. 10295		
		•	State     Registrar		Certifica	ate of Death	R	Reg. No. 4 U I 4	10277		
	Physicia	n/	1. Decedent's Name (First, Middle, Las				Date of Deat     Month	th Day Year	3. Time of Death		
	Medic	al	EVELYN, JEFFE		1		05	17 20			
	Examin	er	4a. Facility Name (if not institution, give  UNIVERSITY OF MAP  5. Social Security Number 6. Se	MANY MEDICAL	CENTER B	ity, Town, or Location of Deat  ALTIMORE  der 1 Year   If Under 24 Hrs			inre		
	Funeral Director		001 13 1	7. Age (In yrs. In	Yrs. Monti		8. Date of Birth (Month, Day,		thplace (State or Foreign buntry)		
	aryland a-f show fied at	Director	10a. State 10b. County	10c. Cit	y, Town or Location	110	9		10d. Inside City Limits 1  Yes 2 No		
	with the N 23a or 28 1st be not	eral Dir	10e. Street and Number  20543 (OLlas)	alale Crosse	10f.	Zip Code 19933		10g. Citizen of What C	ountry?		
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puertos 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whit Specify:			
21215-0036	within 72 hou giene, ier than "natu i, the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Decedent's L (Give kind of life. DO NOT	work done during most of wo	rking Sistant	16b. Kind of Business	/Industry		
Maryland	the filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last)	e Ross S		18. Mother's Na	me (First, Middle, M	Maiden Surname)			
	and 2 should be fi Health and Mental tem 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Ty		19b. Mailing Addr 2054	ess (Street and Number or Ru	Iral Route Number,		ip Code) ù   ÚT)		
altimore,	Page ment c ant: If ury or		20a. Method of Disposition  1	Removal from State	Place of Disposition (I cemetery, crematory (	enutary May	Date (33,2012	20c Location - Sity of	Delaware		
Bal	permit. Departr Imports any inji		21. Signature of Funeral Service Licens	Jours	F	and Address of Facility  Jashington S		uneral Ham abridge, A	P.H.		
الد	h, sician/	100	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	olications that caused the deat ne cause on each line.	th. Do not enter the m		or respiratory arre	est,	Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.								
09	icate be executed physician and is the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a consequence.  Due to or as a consequence.							
. Box 68760	death certif ne attending ed for use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1  Live Birth 2  Feta 4  Pregnant at time of o	al death 3 🔲 Ectop			23d. Date of de Month	elivery Day Year		
s, P.O.	iires that th signed by Id be detac	by	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlyi	ng cause given in Part I.		3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown			
Division of Vital Records,	Hospital or Attending Physician: The law requires that the 44 hours after death. Funeral Director: After this certificate has been signed by the funeral director, page 2 should be detach thely filled in by the funeral director, page 2 should be detach.	Completed					24a. Was a autops perfor 1 □ Yes	sy prior to med? death?	utopsy findings available completion of cause of		
ta	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (Che	eck only one)	Later			
Ž	Phys this caral dii	5	1 Yes 2 No  27. Manner of Death	1 Inpatient 2 2	ER/Outpatient 3 28b. Time of	DOA 4 U Nursing I		ence 6 Other (Spe	cify)		
ion o	tending Ph death. tor: After thi the funeral	Certificate	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)							
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		City or Towr					
	ne Hospital in 24 hours ne Funeral I pletely filled	Medical	(Check 2 Medical Exami	ner: To the best of my know ner: On the basis of examination e Practitioner: To the best of r	n and/or investigation.	in my opinion, death occurred	at the time, date an	nd place, and due to the	cause(s) and manner stated.		
_	To the within 2 To the comple		29b. Signature and title of certifier  ASA AS MD		29c. License number	2		od. Date signed (Month, Day, Year) 5/17/2012			
	TC		30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type, Print)						
	Sta	te	SOWMYA PAUL, MD 31. Date filed (Month, Day, Year)	32 Registrar's Signar	ST. / DAL	IMOKE/MD/21	201		<del></del>		
	Registra	ar	PIAT & 4 20	IZ Comme	O. Dark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Louise Ruth KOFFSKY Physician/ May 20, 2012 2:07 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 4900 Falstone Avenue Chevy Chase Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Apr. 15 Year 1920 1 □ M 2X□ F Delaware 92 **Director** <u> 222-16-7317</u> Usual Residence of Decedent Show 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 4900 Falstone Avenue Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: white Completed 3 ☐XWidowed 4 ☐ Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ ont of Health and Menta It: If item 27 is marked or other traumatic ev Esther Raybin Morris Zurkow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code, 4708 Windom Pl., NW, Washington, DC 20016 Paul Koffsky, Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place King David Memorial Garden 05/22/12 Department (Important: Il any injury or Falls Church, VA 21. Signature of Furerans Torchinsky Hebrew Funeral Home 20012 <u> 254 Carroll St.,</u> NW, Washington, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami Gause (Disease or illijury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ed by the attending physicia detached for use as the buri To the Hospital or Attending Physician: The law requires that the death certificate be eximiting 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician properties of filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \subseteq \text{ Yes} \quad 2 \text{ X No} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 🔼 Natural 5  $\square$  Pending injury Accident Investigation 6 Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day Joselyne kouatchou, ms May 21, 2012 D63748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 4041 Powder Mill Rd., #600, Calverton, MD 20705 Jocelyne Kouatchou,

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NAY 23 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 22 Day Physician/ JOAN G. KNEUSSL 201º2 8:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac 11919 Coldstream Drive If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) Director 1 □ M 2 🛣 F 578-42-9864 80 Jan. 6, New York Usual Residence of Decede 28a-f show 10d. Inside City Limits ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Maryland Potomac Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11919 Coldstream Drive 20854 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian an "natural", or iter Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 K Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry e filed wha. عاط Hygiene. خود than "r" life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the should be filed with and Mental Hygien. Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dennick Herbert Grambow Marion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or any James Kenneth Kneussl, Coldstream Drive, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/22/2012 Alexandria, Virginia Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physiciani Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the burial physician Physician/Medical certificate be P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Month Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director. After this certificate I Yes 2 X No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Investigation filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗹 Certifying Physician: To the best 🔊 my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Z completely f Medical Examiner: On the Certificing Barse Practit of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

31. Date filed (Month, Day, Year) 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one 29b. Signature and title of

29c. License number

D 33293

29d. Date signed (Month, Day, Year)

May 22, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of F tificate of L			giene Reg. No. 20 1	2 18298
ı	Physicia Medic		1. Decedent's Name (First, Middle, Dorothy	<sup>Last)</sup> Kaufn	nan			2. Date of De Month May 22		3. Time of Death 11:30 A M
$\bigcirc$	Examin		4a. Facility Name (if not institution, g 3200 N. Leisure	ive street and number) World Blvd. #91	12		r Location of Death		4c. County of D Montgor	
8	Funeral Director		579-01-6401	7. Age (In yrs. I	y, Year)	Birthplace (State or Foreign Country)				
	yland •f show ed at	tor	Usual Residence of Decedent  10a, State  10b. County	_	ty, Town or Lo			Feb. 7	, 1915 <u>  F</u>	10d. Inside City Limits  1  Yes 2  No
	h the Mar a or 28a- be notifi	al Director	Maryland   Montg	- · ·	ilver S	10f. Zip Code 209	206		10g. Citizen of What	Country?
	death wit items 23 ner must	Funeral	3200 N. Leisure	12. Was Decedent Ever in U.S Armed Forces?			ispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian,
0036	ours after ttural", or al Exami	eted by	1 Never Married 2 Married 3 Wildowed 4 Divorced  15. Decedent	If Yes, Give Year or Dates.		Yes 2 🕅 No			Specify:	white
21215-0036	/ithin 72 hailene.	Completed	(Specify only highest		(Give i		during most of work	ing	Saks Fif Departme	th Avenue nt Store
Maryland 2	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, La:  Morris Barr	st)			18. Mother's Nam <b>Anna</b>	e (First, Middle, Shuste	Maiden Sumame) <b>Y</b>	
, Man	d 2 shoul alth and I 27 is ma er trauma		19a. Informant's Name/Relationship Samuel Kaufman,						er, City or Town, State, ersburg, M	
Baltimore,	Page 1 an ent of He nt: If iterr ry or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Qther (Sp	20b. F	cemetery, cren	sition (Name of natory or other place	ardens 05	Date / 24 / 1 2	20c. Location - City	·
Balti	permit. F Departm Importa any inju		21. Sign ture of Funeral Service L	or size	<b>4</b> 2	orchinsky	* Hebrew	Funeral		
	nysician/		shock, or heart failure. List on Immediate Cause (Final	omplications that caused the deat	th. Do not ente	er the mode of dyin				Approximate Interval Between Onset and Death
1	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		30				
	70	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	ati certificate be executed attending physician and for use as the buriation	ical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					
Box 68760	erificate ding phys se as the		IF FEMALE;	23c. If yes, outcome of pregna	ancv				l and put of	dulin
. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 bhours after that Attending physiciate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 X No 9 Unknown	1 Live Birth 2 Fets 4 Pregnant at time of 6	al death 3	Ectopic pregnand Other (specify)			23d. Date of Month	Day Year
ls, P.O.	uires that the dea n signed by the a uld be detached f	by	Part II. Other significant condition		e to the cause of death?  Probably 4 🗆 Unknown					
Division of Vital Records,	he law requirer ite has been signage 2 should b	Completed						24a. Was auto perfo 1 \subseteq Yes	psy prior prmed? death	autopsy findings available to completion of cause of 1? Yes 2 \(\sumbed{\subset}\) No
/ital	<b>hysician:</b> The law inscentificate has the director, page 2 s	To Be C	25. Was case referred to medical examiner?  1  Yes 2 X No	Hospital:	EP/Outpation	Oth	ace of Death (Chec	k only one)	dence 6 Other (Sp	
n of	ding Phy th. After this funeral o		27. Manner of Death  1 🖾 Natural 5 🗆 Pending 2 🗀 Accident Investiga	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	v at		now injury occurred	is a second
ivisio	al or Attendates after death	Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be		eet, factory, office		28f. Location (S City or Tov	Street and Number or vn, State)	Rural Route Number,
<b>—</b>	To the Hospital or Attend within 24 hours after death to the Funeral Director. Yes completely filled in by the	Medical	(Check 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examinatio Nurse Practitioner: To the best of r	n and/or invest	tigation, in my opinio	on, death occurred a	t the time, date a	and place, and due to t	he cause(s) and manner stated.
	with To the Com		29b. Signature and title of certifier	It lew M		29c. Licenso			May 22, 2	
			30. Name and address of person w	no completed cause of death (Item	n 23a) (Type, F <b>Drive</b>	rint) , #100, R	Rockville	, MD 20	0850	
100	Stat Registra		31. Date filed (Month, Day, Year)  MAY 23 2012	32. Registrar's Signa	de la la	J.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 21, Year Barbara Kuntz 2012 Α. 9:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12140 Pine Tree Lane Calvert Lusby 5. Social Security Number **Funeral** . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Year 935 577-44-9501 1 M 2 X F Months Days Hours May 18, Director Washington DC Usual Residence of Decedent or 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Calvert Lusby 1 🗆 Yes 2 ី No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 12140 Pine Tree Lane 20657 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XXIVo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 YNO Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Clair Madeline Digman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hankins -Daughter 12140 Pine Tree Lane, Lusby, MD20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June<sup>Dat</sup>2. 1XXBurial 2 Cremation 3 Removal from State 2012 Brentwood, Maryland Ft. Lincoln Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home 8200 Jennifer Lane, Owings, MD 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0.10n cano 1ear Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month 9 Unknown P.O. I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of e Hospital or Attending Physician: The law 1 24 hours after death. e Funeral Director. After this certificate has L leted filled in by the funeral director, page 2 s' autopsy 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) ဂ္ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

dRW 4

State Registrar 30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

29c. License number

Prince Frederick MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 15/2012 Physician/ James Fielding Lewis III 1029 ам Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** AAMC Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Months Days Hours 269-34-2614 **Director** XX M 2 - F 72 9/29/1939 Ohio Vrs Usual Residence of Deceden 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State Examiner must be notified at Director Edgewater 1 Yes XX No Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA with 23a 21037 102 Waterside Ct. items death 1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinonone. Completed by 1 Never Married XX Married 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 🛣 No Specify: 3 Divorced 4 Divorced Vietnam 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Racing 4 Horseman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Hester Dean James F. Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21037 102 Waterside Ct. Edgewater, Wife Linda Zang 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/19/2012 | Galesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Quaker Burying Ground! 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Furieral Service Licens 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** 2010GE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ sate has been signed by the atte page 2 should be detached for in the past 12 months? Month Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No To Be ( 26. Place of Death (Check only one) 25. Was case referred to medica examiner? Hospital: Other: 2 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 \sum Yes 2 \subseteq No 28d. Describe how injury occurred Certificate: injury 5 Pending I Director. A Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

1

State Registrar

address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an

29b. Signatuy

31. Date filed

tle of certifier

2001 Media

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:47 8 Month Physician/ William Harry Larmore Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Lake Wicom Salisbury 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral Months 1 X M 2 □ F 0271771925 Maryland 87 218-16-6597 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho njury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 31739 Old Ocean City Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Army If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced WW II Completed Year or Dates. 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Construction Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elizabeth Ellen Bounds William Harry Larmore Sr. permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Larmore/Son 31739 Old Ocean City Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/23/2012 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Licensee Holloway Funeral Home Profes 501 Snow Hill Rd., Salisbury 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) SCVD Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Be Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s performed ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence Hospice ပ 1 Inpatient 2 ER/Outpatient 3 IDOA Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Ab Certificate: 28c. Injury at work Matural 🗠 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63199 20/12 Name and address of person who completed cause of death (Item 23a) (Type, Print)
OFESH OHRA 910EASTELN SHO SHORE DE SALISBURY MD. 21804 OGESH

Registrar

31. Date filed (Month, Day, Year)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Ann Lee aði Medical 4a. Facility Name (if npt institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c.,County of Death 005ta comic Social Security Number If Under 24 Hirs. Hours Win. If Under 1 Year . Age (In vrs. last birthday) **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 262-56-0128 1 🗆 M 2 🖾 F 74 Usual Residence of Deced 12/20/1937 Florida permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28e-f show enry Injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset 1 Yes 2 X No Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27041 Oriole Road 21853 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Baker Subway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frederick Barmore Elizabeth Haves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rustina N. Padilla/Daughter 10534 William Sharpless Rd, Princess Anne, MD21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🖾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 5/23/2012 Salisbury, MD Signatu H&NTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ End Onset and Death Sta disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit Hospital or Attending Physicien: The law requires that the deeth certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 1 Yes 2 No 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ale Natural 🗹 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowled at death occurred at the time, date and lace, and due to the (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title offcertifier Date signed (Month, Dav. Year) D63199 20/12. TC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY EASTERN SHORE DR. OGESH 21844 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Stan 1ay Medical 4b. Gity, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Med If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours 051-38-8054 65 Director 1 X M 2 □ F May 18, 1947 New York 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director 1 ☐ Yes 2 🛣 No Galway Saratoga New York 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Numbe USA 12074 23a permit. Page 1 and 2 should be filed within 72 hours after death with 2620 Hermance Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Medical Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Year or Dates Specify: white 'natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) alth and Mental Hygiene.

27 is marked other than it traumatic event, the M College (1-4 or 5+) drug store pharmacist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Katherine Byer Stanley Minarski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other traconce. 2620 Hermance Road, Galway, N.Y. 12074 Margaret Minarski - wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory 5/29/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 21740 415 E. Wilson Blvd., Hagerstown, Md. Kaled Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a la consequence of) 20 hours **Examiner** neura 5 MG Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a car equence of): and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ျင After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural work? injury 5 Pending Investigation Could not be 2 Accident
3 Sulcide Director: / 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier (Check 3 [ 29b. Signature and title of cert

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

5932

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shirley M. Martin 2ŎĨ2 May 9:30 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Anne Arundel 1697 Tarleton Way Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 577-34-1093 83 1 M 2 XF 1928 Dec. 24, Washington, DC 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2X No FL Punta Gorda Charlotte 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 33950 USA 29200 S. Jones Loop Rd., #171 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔼 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by White 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed)  $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4 or 5+) Director of Human Resources Goddard Space Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Johnson William Frederick Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1697 Tarleton Way, Crofton, MD 21114 Sandra K. Lubonski / Daughter 20a. Method of Disposition
1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Metro Crematory 5/21/2012 4 Donation 5 Other (Specify) Baltimore, MD 21. Signal e of Finance Cellic Insee 22. Name and Address of Facility Feall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Bert 1. Enter the disea shock, or hear failure. Immediate Cause (Final disease or condition disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Interval Between Onset and Death Pancheank resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery

Physician Medical Examiner

permit. Page 1 a
Department of H
Important: If ite
any injury or ott

**Funeral Director** 

or 28a-f show

Page 1 and 2 should be filed within 72 hours after death with the Maryland trent of Health and Mental Hygiene. That If Ifew 22 is marked other than "natural", or items 23a or 28a-f sho itany to the traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified as

Baltimore, Maryland 21215-0036

ng physician and as the burial-tran attending physician for use as the burial has e 2 within 24 hours after death.

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Live Birth 2 - Fetal death Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 🗷 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannes of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20052087

MD

5-21-2012

29d. Date signed (Month, Day, Year)

CAMBRILLS 2401 BRANZENZI 31. Date filed (Month, Day, Year)

(Check

29b. Signature and title of certific

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 2012 Morris 8:20 A M Leonard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Delmar 9100 Parsonsburg Road Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Min (Month, Day, Year, 3-28-1917 1 🛛 M 2 🗆 F Maryland Director 222-05-3942 95 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Delmar Wicomico MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21875 USA 9100 Parsonsburg Road hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Owner/Operator 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Eva Gordy Morris Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9100 Parsonsburg Road, Delmar, Maryland 21875 Ida Mae Morris - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 6-2-2012 Delmar, Maryland Melson Cemetery of Funeral Service Licensee Bounds Funeral Home 21. Signature 22, Name and Address of Facility 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying the burial-transit Cause (Disease or iiniury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate b Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one

Registrar
DHMH 17 Rev 7/2009

State

Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Plea									II Copies		_	ible.		
	-	For State		Sta	ate of N	/larylan	,				and N	Mental Hyg	giene	e	^ I (		000
		Registrar  1. Decedent's Name	e (First, Middle	Last)			Ce	ertificat	e or L	Jeath		2. Date of Dea	Reg. No	0.	116	3. Time of	Openth T
Physicia Medic			Elean		ller							May 18	Day Year				
Examin		4a. Facility Name (if	4b. City	4b. City, Town, or Location of Death				4c. County of Death									
-		Atrium A  5. Social Security Nu		d L1V1 6. Sex		ge (In yrs. la	ast hirthday	) If Unde	Silver Spring				h	Mo	ntgo		r Foreian
Funeral Director	١	579-14-20	89	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day	, Year)	•						
. A →		Usual Residence of	of Decedent									Sept. 1	0, 1	.922		ington, 10d. Inside Cit	
arylan a-f sh fied a	Director	133 2 3 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7													1 🗌 Yes		
or 28 e noti		10e. Street and Num		onegom.	c r y	1	DIIVE	10f. Zip Code 10g. Citizen					itizen of \	What Cou	ntry?		
s 23a	Funeral	9739 Не	edin Dr	ive					209	03			USA	A			
r item	린	11. Marital Status	Armed Forces?					. Was Dece If Yes, spe	edent of H ecify Cuba	ispanic On ın, Mexicar	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.			
s after	ed by	1 ☐ Never Mami 3 🌁 Widowed	☐ Yes 2 k No Yes, Give ear or Dates.			1 🗌 Yes	1 ☐ Yes 2X No Specify:					Specify: White					
2 hour	Completed	(Spe	15. Deceder	nt's Education			16a. Dec	edent's Usi	ual Occup	ation	t of work	ina	16b. i	Kind of B	usiness/Ir	ndustry	
ithin 7 ene. than	E S	Elementary/Secondary (0-12) College (1-4				life DO NOT use retired							taria	1			
iled w Il Hygi other	Be	17. Father's Name (First, Middle, Last)											le, Maiden Surname)				
ld be f Menta arked atic e	ဍ	Ernest S			Ada	St	ewart	_									
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Patricia				hter						al Route Number		or Town, S	State, Zip	Code)	
I and if Healt item 2		20a. Method of Disp			,	20b. F	Place of Dis	position (Na	me of					Location -	- City or T	own, State	
Page nent or n		1 🖾 Burial 2 I 4 ☐ Donation			al from Sta			ematory or eaven			May	<sup>Pat</sup> 24, 2012	Sil	ver	Spri	ng, MD	
permit. Departn Importa any Inju		21. Signature of Fur	21. Signature of Funeral Service Licensee  22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901														
₹0.5 m 0	_	23a. Part 1. Enter to	lef	/ )/	Ty							"		er S	prin T		
Obviniena /		shock, or hear	rt failure. List o	only one caus	e on each l	ne.			de or dyll	y, such as	Carciac	or respiratory arr	cst,			Approximate Interval Bets Onset and D	ween
Physician/ , Medical		disease or condition resulting in death)		a		er's ]		tia	· ·						$\dashv$		
Examiner	ڀ	Sequentially list conditions, Coronary Artery Disease															
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):															
executed an and rial-transit	Exa																
	dical																
artifica ding ph	Physician/Medica	IF FEMALE:		23c If	ves outcom	ne of pregna	ncv										
attend I for us	cian	23b. Was decedent in the past 12 r 1 Yes 2	months?	1	Live Birtl	n 2 ☐ Feta at time of a	al death 3	☐ Ectopic pregnancy ☐ Other (specify)					23d. Date of delivery  Month Day Year				
the de by the tachec	hysi	g Unknown		9	Unknow	1											
ss that igned be de	by F	Part II. Other signif	ficant condition	ons contribut	ing to death	but not res	sulting in th	e underlying	g cause gi	ven in Part	1.					the cause of debaths	
require	eted											24a. Was				opsy findings a	
e has l age 2 s	Completed by											autor perfo	osv		prior to co death?	ompletion of ca	ause of
an: Th	0	25. Was case referre	ed to medical						26. P	ace of Dea	ith (Chec	l 1 ∐ Yes k only one)	2141			2 🗌 No	
hysic this ce al direc	To B	1 ☐ Yes 2 ☐		Hospita	1 🗌 Inp	atient 2 🗆			Oth	er: 4 🗌 N	ursing Ho	ome 5 🗆 Resid	dence			ed Livi	Lng
ding F h. After t funer	:ate:	27. Manner of Deatl 1 ☒ Natural 2 ☐ Accident	5 🗌 Pendir	ng	a. Date of ir (Month, E	njury Da <i>y, Year)</i>	28b. Time injur		28c. Injur work		l No	28d. Describe h	ow inju	iry occurr	ed		
Atten er deal ector: by the	Certificate:	3 Suicide 4 Homicide	Investi 6  Could determ	not be		njury - At ho				100 2 2	1110	28f. Location (S			er or Rura	al Route Numb	er,
ital or urs afte ral Dir lled in	a Ce					etc. (Specif)						City or Tow					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	🛚 💹 Medical E	Examiner: Or	the basis o	f examinatio	n and/or inv	estigation, is	n my opini	on, death o	ocurred a	and due to the ca	ind plac	ce, and du	e to the c	ause(s) and ma	nner stated.
To the within To the compl	Σ	only one) 3 29b. Signature and			utioner: 10	trie best of i	11y Kriowied		curred at c. Licens		ite and pi	ace, and due to t		<del>``</del>		Day, Year)	
10		► Wi	lokun	ren	J.	NIY	alo	$\overline{}$	D4	528	5		W	lay	21,	2012	
		30. Name and addre							vd	West	S+1	ver Spr	ing	MD	209	 )1	
Stat		31. Date filed (Mont						west		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	011	ver opr	Tug	, 111/	207		
Registra	ar	m A	11 60	LU1Z	Cenu	a p	. 19										

Registrar DHMH 17 Rev 06-2011 amend 20a-c, per fh, g928 6-4-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Amend Item 3 State of Maryland State Registrar	<b>06/08</b> Cen	72012dib tificate of D	eaith and iv eath	rentai mygi Re	eg. No. 2012	2 18307	
Ħ	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Larry Lee Maxwell				2. Date of Death Month May 17	Day Year	3. Time of Death <b>2:20p</b> M	
	Medic Examin		4a. Facility Name (if not institution, give street and number) 303 70th Street		4b. City, Town, or L		4c. County of Deat	4c. County of Death Prince George's		
- A-A-A-	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Lindor 24 Hrs	8. Date of Birth (Month, Day,	Q Birthalasa (State or Foreign		
		. h	0 9 6 - 3 6 - 4 2 5 6  Usual Residence of Decedent  10a. State  10b. County  10c. City,	Town or Loc	easant		* 24		10d. Inside City Limits	
	ne Maryla or 28a-f s notified	Funeral Director	Md Prince George's Sea	L PI	10f, Zip Code		_1	0g. Citizen of What Co	1 X Yes 2 □ No untry?	
	ms 23a must be	uneral	303 70th Street  11. Marital Status 12. Was Decedent Ever in U.S.	13. V	20743 Vas Decedent of His	panic Origin? (Spe		U • SA •		
920	e 1 and 2 should be filed within 72 hours after death with the Maryland to fleath and Mental Hygiene. It of Heath and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 X Divorced 3 Widowed 4 X Divorced	If	Yes, specify Cuban	, Mexican, Puerto I	Rican, etc.)	Black, White	e, etc.	
21215-0036	n 72 hou e. aan "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Flectrian				16b. Kind of Business Industry Private		
1d 21	filed withi al Hygiene d other th vent, the	Be	12th  17. Father's Name (First, Middle, Last)	ETEC		18. Mother's Name	(First, Middle, M	e, Maiden Surname) nson Maxwell		
Baltimore, Maryland	12 should be file alth and Mental H 27 is marked o r traumatic eve	욘	Leroy Maxwell  19a. Informant's Name/Relationship (Type, Print)		ng Address (Street ar	Street and Number or Rural Route Number, City or Town, State, Zip Code)				
re, M	1 and 2 s if Health a item 27 i			ce of Dispos	70th Sti			20c. Location - City or		
Itimo	t. Pag tmen tant; tant;			rdale	Park Crema	tory $5/30$	/2012 I	Riverdale, in Funer	<b>MD,20732</b>	
Ba	permit Depar Impor any in	9	* IMME MA	25	18 Penn	sylvan'i	a Ave S	SE Washin	al Home gtonDC 20020	
	nysician/ Medical	22	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a conseque	ODA	huctive	pulman	ary des	ease	Interval Between Onset and Death	
-	Examiner	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions).	ence of):			0			
	cate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Libease or linjury that initiated events resulting in death) Last  c.  Due to (or as a consequence)	ence of):						
092	cate be e physicia s the buri	edical	d							
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	livery Day Year				
ls, P.O.	uires that the n signed by lid be detac		Part II. Other significant conditions contributing to death but not resu	en in Part I.		oacco use contribute to	o the cause of death? Probably 4 Unknown			
Division of Vital Records,	sician: The law requ s certificate has beer lirector, page 2 shou	Completed					24a. Was a autops perfor 1 \(\sum \) Yes	prior to death?	utopsy findings available completion of cause of	
Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1  Inpatient 2  E	ER/Outpatier	- Othe	ace of Death <i>(Checi</i> or: 4 \(\sum_\) Nursing Ho	1	ence 6 Other (Spec	cify)	
n of	nding Phy ath. :: After thi e funeral	icate:	27. Manner of Death  1 X Natural 5 ☐ Pending (Month, Day, Year)  2 ☐ Accident Investigation	28b. Time of injury	work'	rat ? Yes 2 □ No	28d. Describe ho	w injury occurred		
Division	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page:	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)		eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,	
_	e Hospite 124 hours e Funera bleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle only one) 3 Certifying Nurse Practioner: To the best of my	and/or inves	tigation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.	
	To the within to To the comp		29b. Signature and title of certifier  Augustus Mannan MJ		29c. License	500	2	29d. Date signed (Month, Day, Year) 05-24-2012		
•	1		30. Name and address of person who completed cause of death (Item 9200 SASILUT STEZO)	23a) (Type, F		20774	4			
÷	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 8 2012  32 Registrar's Signatu	lire Saa	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month 2012<sup>Year</sup> Physician/ 4:42 Elizabeth Mary Nigh Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Williamsport Nursing Home Williamsport If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 24,1913 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 214-09-6834 98 **Director** 1 □ M 2 🗓 F Maryland 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f sho should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Washington County Williamsport Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 U.S.A. 154 Artizan St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status "natural", or iter Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other throng any injury or other traumatic event, the Shoe Store Sales Associate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ada Florence McElroy John Garfield Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17812 Burnside Ave. Hagerstown, MD 21740 Ruby N. Schleigh-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | 5-30-2012 Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a sequence of) **Examiner** Sequentially list conditions, it day, reading to marrediate cause. Enter Underlying Examine Due to (or as a nonsequence of) sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Other (specify) the a Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No has page 2 death? 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 5  $\square$  Pending Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director Aft completely filled n by the fu Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 05 address of person who completed cause of death (Item 23a) (Type, Print) TW-5 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ :/DM ani Medical mility Name (if not institution 4c. County of Death give street and number. **Examiner** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral Min (Month, Day, Year) Country) 58 577-04-9085 **Director** 1 🛛 M 2 🗆 F 29, 1954 Ghana Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director Hyattsville 1 Yes 2 No MD Prince George's 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 20782 1005 Chillum Rd, #413 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Accountant traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Sampong Ahenkora Osei 19a. Informant's Name/Relationship (Type, Print)  ${\sf Spouse}$ Department of Health and Important: If item 27 is n any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Chillum Road, #413, Hyattsville, MD 20782 Felicia Aderinto Omolade 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Resurrection Cemetery 5/26/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home maral Service Bowie, MD 6512 NW Crain Hwy., complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on one cause in each line. Part 1. Enter the disease, or coshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequer ce of): **Examiner** Esquentially lict conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has after death.

Director: After this certificate I filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) nos Dice 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending atural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 2012 of person who completed cause of death (Item 23a) (Type, Print) Name and address exactorin 31. Date filed (Month, Date istrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 250M 100m 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F **Director** 577-40-9189 80 05/27/1931 Washington, DC 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 20754 11800 Rivershore Drive Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🛣 No Specify: Specify: 3 H Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Spencer Hamilton Carrico Mary Ruth McDaniel Gregan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2080 Huntingfields Drive, Huntingtown, MD 20639 Beverly Davis/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington National 05/30/2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign sture of Funeral 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa W. Mounts 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months' Month Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled in by the funeral director, page 2 autopsy 1 Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name d address of person who completed cause of death (Item 23a) (Type, Print) 32. Registr 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr. 928,06/08/2012dhb Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day MAY Month 2012 Year **Physician** 30 3:30 рм DONALD SCOTT OTHOSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Chestertown 11040 Kylie Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) May 7 1960 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 🔀 M 2 🗆 F 52 222-58-1132 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Modical Examinat must bu nutflied at 10a. State 1 ☐ Yes 2X No Funeral Director MD Kent Chestertown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11040 Kylie Lane 21620 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ∐Yes 2X No Specify: Specify <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If Item 27 Is marked other the any ijury or other traumatic event, IT-11 once. Real Estate Investor Self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald E. Othoson Ruth Gillespie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Angela Othoson (wife) 11040 Kylie Lane Chestertown, MD. 21620 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kent Cremation Services 5/31/12 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licenses <sup>22</sup>. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 5 Other (specify) ∃Yes 2□No P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Liver Failure, Kidney Failure 24a. Was an cate has t page 2 s autopsy performed?

1 Yes 2 No certificate 1 ☐Yes 2 ☐No Division of Vital this certific af director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Natural Natural after death.

Director: Ald in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hour. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 005 1786 1-13

State Registrar 30. Name and address of person who completed

Andrew S. Ferguson,

JUN N 8 2012

31. Date filed (Month, Day, Year)

32

Chestertown, MD. 21620

ause of death (Item 23a) (Type, Print)

120 Speer Rd.

M.D.

32. Registrar's Signature

12-04155 Vivian Ogg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 18312

		1- For State Certificate	of Death	Re	eg. No.				
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Dear	th Day Year	3. Time of Death			
Medical Exami		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -							
		Facility Name (if not institution, give street and number)     24513 Etchison Drive	4b. City, Town, or Location of Dear		4c. County of Death Montgomery	h			
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Laytonsville Gaither  If Under 1 Year If Under 24Hi	sburg	th(MM/DD/YYYY) 9. Bit	rthnlane (State or			
Funeral Director		212-38-6216 <sub>1 M 2 F</sub> 72	n	Foreig	West West				
any		Usual Residence of Decedent  10a, State 10b, County 10c. City, Town or Le	ocation			10d. Inside City Limits			
<b>E</b>			ithersburg			1 Yes 2 X No			
daryland 28a-f show 1 at once.	핡	10e. Street and Number	10f. Zip Code	I 1	0g. Citizen of What Cou	ntry?			
e Mar or 28	Director	24513 Etchison Drive	20882	1	United States				
death with the Maryland or items 23a or 28a-f sho must be notified at once.			Was Decedent of Hispanic Origin? ( §	Specify Yes or No	- 14. Race - Amer	ican Indian, Black,			
eath v	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puert		White, etc.				
fter d		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify:	White			
ours a			dent's Usual Occupation (Give kind of g most of working life. DO NOT use re		16b. Kind of Business/	Industry			
6 172 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		, and a	Own H	omo			
within jene.	틹	12 0 17. Father's Name (First, Middle, Last)	Homemaker	on /First Baidello B	Maiden Surname)	OTIE -			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Bernard R. Somers	Beatri						
212 ald be Mentz mark			ailing Address (Street and Number or			e, Zip Code)			
MD d 2 sho ith and a 27 is umatic	٦,	Joseph E. Ogg / Husband 24	513 Etchison Driv	re, Gaith	nersburg, M	D 20882			
	Ī		sposition (Name of cemetery, or other place)	Date	20c. Location - City or	Town, State			
Baltimore, permit. Pages I an Department of Hea Important: If iter	-	Months 2 Clemation 3 Themoval non-state		06/12	Etchison	, Maryland			
alti mit. ] partm ports ury o	Ì	Solidion of Choling			Barber Fun	eral Home			
E A B B		Koy w. Barles	P.O. Box 5038, La	ytonsvi	lle, Maryla	nd 20882			
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enfailure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death)	ardiovascular Disease			Death			
	-	b							
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated exerts resulting in death). Last  Due to (or as a consequence of):							
cecuted n and - transit		events resulting in death) Last Due to (or as a consequence or):							
क है व	Medical	UNPENDED x AMENDED #4b, per me, g9	28 6-8-12 sm						
760, icate be exg physician the burial.	ĕ	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	y			
687 ertific ding p	$\geq 1$	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy	Month	Day Year			
Box 68's death certified he attending ed for use as	Physician	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)			'			
D. B tribe d by the		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?			
, P.( res tha signed be det	힐			1 Yes	2 No 3 Pro	bably 4 🗹 Unknown			
ords, w requir s been s should!	Completed			24a, Was autop		utopsy findings available completion of cause of			
e law e has ge 2 sl	틹				rmed? death?				
ital Rec ician: The I s certificate I rector, page	ပ္မ	25. Was case referred to medical	26.Place of Death (Chec		2 10 1	65 2 140			
Vita ysicia ysicia direct	PB P	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other Nurs	ing Home 5	Residence 6 🗸 Othe	r: Scene			
n of ding Ph		27. Manner of Death 28a. Date of Injury 28b. Time	of Injury 28c. Injury at Work?	28d. Describe	how injury occurred				
itendii leath. tor: /	랿	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No						
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the state death.  To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	Certification	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Ruitate)	ural Route Number, City			
Oj sepital hours a neral I	Ö	4 Homicide determined (Specify) 29a. Certifier							
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one)  Certifying Physician: To the best of my knowledge, death o							
To T vith com	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo				
		all he Wint	O.C.M.E.		June 2, 2012				
	-	30. Name and address of person who completed cause of death (Item 23a)			1				
		Melissa Brassell, MD Assistant Medical Examiner 900	W. Baltimore Street, Baltim	ore, MD 2122	23				
	22.7	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regist	ar	111N 0 8 2012 Cenera p. 1900							

	#4a per Health De		5-22-12 KA	Please H	Type or Pr State of M										. 18313
		1	For State Registrar			, , , , , , , , , , , ,		tificate					Reg. No	C 0 1 E	. 10010
			Decedent's Name	(First, Middle, Las	t)							2. Date of De		ay Year	3. Time of Death
	Physicia Medic		Rita Beve	erly Prin	tz							Month 5		15 20	0/2 10:32a M
The same of	Examin		4a. Facility Name (if							Location of			- 1	c. County of De	
7			AAMC 80		ain Way	#108 ge (In yrs. Ia		If Under		polis		8, Date of Bi		Anne Ar	runde1
	Funeral Director		5. Social Security N. 089–22–61		DM 2XXXF	ge (iii yrs. ia. 81			Days	Hours	Min.	(Month, Da	ay, Year)	0	ountry)
			Usual Residence of Decedent				113.					8/28/	1930		NY
	/land f sho	tor	10a. State	10b. County		10c. City	, Town or Loc								10d. Inside City Limits 1 ☐ Yes ※XX No
	Man 28a-	Director	MD	Anne Ar	undel			Annap		s			10g C	itizen of What (	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>ral</u>	10e. Street and Nun		#108			101. Zip		1401			rog. o	USA	, and the second
	ath w	Funeral	11. Marital Status	wain way	12. Was Decedent	Ever in U.S	. 13. V	Vas Decede			gin? (Spec	cify Yes or No Rican, etc.)	-	14. Race - An	nerican Indian,
9	or ite	by F		ied 2 XXMarried	Armed Forces	? ¶ No		f Yes, speci			, Puerto F	Rican, etc.)		Black, Wh	ite, etc. White
21215-0036	ırs aft ural", II Exa		3 Widowed		If Yes, Give Year or Dates.										
5-0	"nati	Completed	(Spe	15. Decedent's E cify only highest gr			16a. Deced	lent's Usua kind of worl O NOT use	k done d	ation <i>luring m</i> ost	of workir	ng	16b.	Kind of Busines	ss/Industry
12	ithin 7 ene. • than	Con	Elementary/Seco	ondary (0-12)	College (1-4 or 2	5+)		Fice N		ger			Co	nstruct	ion
g 2	led w Hygir other ent, t	m	17. Father's Name (	First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maider	n Surname)	
Maryland	i be fi fental rked tic ev	မ	Leon Alt	er						Dor	othy	Balbe	rg		
ary	hould and N is ma		19a. Informant's Na	ame/Relationship (7	ype, <b>P</b> rint)			-						or Town, State,	
Σ	nd 2 s ealth : m 27 i		Jack Pri		ouse					Way #			1	, MD 2	
altimore,	le 1 al t of H If itel or oth		20a. Method of Disp 1 Burial 2	oosition  Cremation 3	Removal from Sta	te ce	lace of Dispo emetery, crer	natory or ot	ther plac	i		Date		Location - City	
ţ	t. Pag tment rtant: ijury				Removal from Sta	Kne								napolis	
Bal	permit Depar Impor any in	9	21. Signature of Fu	neral Service Incen	see			2. Name and 2. Rids			Har	desty	Fune	ral Hou 1D 2140	ne, P.A.
			23a Part 1. Enter t	he disease. Or	plications that caus	ed the death								10 2140	Approximate
- 1	Maria Maria		shock, or hea	rt failure. List only o	one cause	ine.	_ /	1'0	_	anc					Interval Between Onset and Death
4	Medical		disease or condition resulting in death)		a. Due to (or a	s a consequ	ence of):	1		1710					
Sec.	Examiner														
		iner	Sequentially list co it any, leading to in cause. Enter Unde	nmediale	D. Due to (or a	is a consequ	lence on.								
	xecuted n and ial-transit	Examine	Cause (Disease or that initiated event	injury	C. Due to (or o		iones off:			<del>.</del>	<u> </u>				-
	e exection a sourial-	1=	resulting in death)	Last	Due to (or a	ıs a consequ	ience on.								
68760	aath certificate be ex attending physician I for use as the buria	Physician/Medical			d	<u></u>					_				
687	ertific ding p	Ž	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcon	ne of pregna	incy							23d, Date of	delivery
Вох	atten atten 1 for u	iciai	in the past 12	months?	1 ☐ Live Birt 4 ☐ Pregnan	t at time of o		Ectopic p Other (sp		cy 				Month	Day Year
	the de by the achec	hys	9 Unknowi	1	9 Unknow										
P.O.	requires that the des been signed by the s should be detached	by P	Part II. Other signi	ficant conditions	contributing to deat	but not res	ulting in the	underlying o	cause giv	ven in Part	I.				to the cause of death?
ds,	quires en siç ould b	ted													Probably 4 Unknown
cor	law reh has be ge 2 sh	Completed										24a. Wa aut	s an opsy formed?	prior	autopsy findings available to completion of cause of
Re	The I	Con										1 🗆 Ye		No 1 🗆	Yes 2 No
tal	ician: sertific	Be	25. Was case reference examiner?	_/`	Hospital:				Oth	lace of Dea					
Ę	Physical this carral direction	<u>ا</u>	1 Yes 2		28a. Date of i	njury	ER/Outpatie 28b. Time o		OA Page 1990 Pag	4 ∟ N		28d. Describe		6 Other (Spurry occurred	pecify)
0 0	ding th. After fune	cate	1 Natural 2 Accident	5 Pending		Day, Year)	injury	М	work	kí? ]Yes 2. □	] No		,	,	
sio	Atten r dear	Certificate:	3 Suicide 4 Homicide	6 Could not	be 28e. Place of	Injury - At ho	me, farm, st	reet, factory	y, office						Rural Route Number,
Division of Vital Records,	al or s afte				building,	etc. (Specif)						City or T			4
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	Chook	Medical Evan	ysician: To the best niner: On the basis of	of examination	n and/or inves	stigation, in	my opini-	ion, death o	occurred a	t the time, date	e and pla	ice, and due to t	he cause(s) and manner stated.
	To the Pwithin 24 To the F	Me	only one)	3 Certifying Nu	rse Practitioner: To	the best of r	my knowledge	e, death occ	curred at	the time, da se number	ate and pla	ace, and due t	o the cau	use(s) and mann Date signed (M)	er as stated.
	Vvit O COI		29b. Signature and	Interest Certifier	1.	,		7		1211	2		200,1	-116/	L0/2
	2		OO NOT TO A	ross of parameter	completed cause of	if death (Iten	n 23a) (Time	Print)	1	57 4	2			11017	(
	12		Howari		LDSTEF			6 DE	for	SE	Hu	- y A.	NN,	AP. V	n D_
	Sta	te		oth, Day, Year) Y 2 2 2012		strar's Signa			· · ·			1			
	Registr		MA	1 2 2 2012	Senter	v 3.	- par	No.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 641 M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 217-23-0383 Hours **Director** 1 M 2 X F 83 06/28/1928 India Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Maryland Anne Arundel Riva ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a **Examiner must** 2871 Hambleton Road 21140 USA or items hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. "natural", Specify: 3 XWidowed 4 Divorced Asian Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 Homemaker Home Be be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည Hariram Khilnani Radha Sajnani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Vic Pancholi / Son 2871 Hambleton Rd., Riva, MD 21140 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 05/20/2012 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home re of Funeral Service Licens 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final disease or condition Physician/ AGE NG ESTIVE HEART Medical resulting in death) Due to lor Examiner EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last um as the burial-tran and 15 Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ģ Month Pregnant at time of death should be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? Yes 2 the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospita 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certi poleted cause of death (Item 23a) (Type, Print) Name and address of pers State MAY 22 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per dr., g928,06/08/2012dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ridenour 2012 James Lewis 2:05 P. May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 1118 Moller Ave. Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6 Sex 8. Date of Birth . Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign **X**□ M 2 □ F Feb. 25, 1933 220-28-3761 79 **Director** Yrs Maryland Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. 1 Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1118 Moller Ave. 21740 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Divorced 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiens is marked other th Cabinet Maker Wood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Eirs Middle, Maider Surname) ပ Columbus Victor Ridenour other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18302 Rench Rd. Hagerstown, Md. 21740 If item 27 J. David Ridenour (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State <del>j</del>o May Date 2. 1 Burial 2 Cremation 3 Removal from State injury or Important: I any injury o Smithsburg,Md. Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner char 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and tran resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month 1 Yes 2 9 Unknown the is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes \( 2 \sum \) No 24a. Was an has autopsy page, performed atrial this certificate h twousus Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: \_2 🗌 No 1 X Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending nours after death neral Director: A ifilled in by the fi 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours a the Funeral D mpleted filled i Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and t ٥ 29d, Date signed (Month, Day, Year) DOOG 9992 5/11/ Johns Horkens Commenty Physicians Heigenbau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 12916 Corana Dr. Sul 204

Janus MD

82. Registrar's Signature

jenniter

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Elizabeth Reilly 2012 May 18, 10:42 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6825 Apache Drive Snow Hill Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 212-14-6798 1 M 2 X F 89 09/05/1922 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Marvland Worcester 1 🗆 Yes 2 🙀 No Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6825 Apache Drive 21863 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dental Assistant Dental Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Hobbs Virginia Gartrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3722 Seminole Dr., Snow Hill, MD 21863 James Reilly/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3/ Removal from State 4 Dopation 5 Other (Specify) Salisbury Crematory Salisbury, MD 5/22/2012 . Signature of Fuperal Service Ligenses HOLLOWay Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed for use as the burial-transi pertension Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 - Ectopic pregnancy 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No 1 Yes Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UR

DHMH 17 Rev 06-2011

State Registrar

P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day  $2012^{\text{Year}}$ Norma Hudson Roby 19, May 1:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homewood at Crumland Farms Frederick Frederick . Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 6, 1926 Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 86 1 M 2 K F Min 231-20-9116 Washington, D.C. **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Frederick Frederick 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5694 Crabapple Drive 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 ₺ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Mes Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Electrical Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Hudson Elva Winstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Smith / Daughter 4304 Lynn Burke Rd., Monrovia, MD 21770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 21 2012 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) cemetery, crematory or other place) Resthaven Crematory Frederick, Maryland . Signature Fundament Licensee Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ WVO con Medical resulting in death) Due to or as a consequence of): **Examiner** Sequentially list conditions, it any, he ding to immediate cause. Enter Underlying Examine nding physician and use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 morths?

1 Yes 2 No
9 Unknown signed by the atte Pregnant at time of death
Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No Vital after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2XINO Other 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature 0000012665 May 21, 2012 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 8 1967 TIDREUT, FREDEREK DELLASZ 31. Date filed (Mon Registrar's Signature

Registrar

1:000m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Month Year Physician/ 1:10 PM Freida L. Reed May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Williamsport Williamsport Nursing Home 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) (Month, Pay, **Funeral** 1 □ M 2 🗓 F Mary Land 82 218-24-7685 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State Director 1X Yes 2 No Williamsport Maryland Washington County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 U.S.A. 154 North Artizan St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceden 2.5. Armed Forces? 1 ☐ Yes 2 🎇 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education بالا hiled الدن. •\*al Hygiene. •\*ar than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked out any injury or other traumatic even once. ည Mary Margaret Beard Alfred E. Shives 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1020 Bramly Dr. Hagerstown, MD 21742 Mary Ellen Reed-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkhead Cemetery 6-6-2012 Big Pool, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funcy Service Licens 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ind Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No ☐ Yes 2 🔼 No certificate | within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifie 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 580 C MID Northern

State

Registrar

JUN 08

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5 SARAH VERONA SMITH 8:46 D 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1□ M 2XF MARCH 6, 1919 MARYLAND 93 Director 216-40-4919 Usual Residence of Decedent filed within 72 hours efter death with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1X Yes 2 □ No Director QUEEN ANNE'S SUDLERSVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number UNITED STATES 21668 210 SOUTH CHURCH STREET Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ WHITE 3K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) POSTAL SERVICE POSTAL CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil iment of Health end Mental H tant: If Item 27 ie marked oth ORA MARVEL 2 J. NOBLE HARDESTY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is many and 2 s important: If Item 27 is m any injury or other \*\*\*\* 19a. Informant's Name/Relationship (Type, Print) 7400 MICHAEL AVENUE EASTON, MARYLAND 21601 ROBERT SMITH / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 05/23/12 SUDLERSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEMETERY 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 370 WEST CYPRESS ST. MILLINGTON, MARYLAND 21651 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** MYUCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physiclan/Medical Examiner CORONARY ARTERY attending physician and for use es the buriel-transit or Attanding Physician: The law requires that the death certificete be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown GASTROENTERITIS Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed ATRIAL FIBRILLATION performed? TUVES ZENO 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours efter death. 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical Vithin 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0041587 5-18-2012 12 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) SPEER ROAD CHESTERTOWN, MD 21620 MS 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ May D2012 George Washington Staton 19, 0058 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9500 Coastal Highway Ocean City Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 220-32-9671 Director 1 X M 2 □ F 74 Yrs 02/22/1938 Maryland 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Worcester Ocean City 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9500 Coastal Highway 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Cellular æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Staton Florence Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, and 2 s Health a Nancy C. Staton/Wife 9500 Coastal Highway, Ocean City, MD 21842 permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parsons Cemetery 5/23/2012 Salisbury, MD 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THE LOSCIENO TIC CANDINASCULAR DISEASE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MY PORTENSION Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): HYPERLIP DO MA or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ş Records, cate has been sig ; page 2 should b Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate funeral director, pag 1 🗌 Yes\_ 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending iniury 24 hours after death. Funerel Director: A Accident Suicide 1 Yes 2 No Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the P within 2. To the F only one 29c. License number 1246257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASTANEDA MO 10524 OLD OCODNATY BUD. BORUNINO 21811 COW IN

State Registrar 31. Date filed (Month, Day, Year)

4

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 18 Physician/ 1:25 a M Mark H. Tise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 2413 Kelford Lane Bowie If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 230-88-3238 1 □XM 2 □ F Director 54 Nov. 25, 1957 California filed within 72 hours after death with the Maryland ral Hygiene. d other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Bowie MD Prince George's 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20715 2413 Kelford Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) 4 Security Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked oth eny Injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Marian Jones Donald Tise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2413 Kelford Lane, Bowie, MD 20715 Christine M. Tise/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 5-19-2012 Baltimore, MD Donation 5 Other (Specify) Crematory Metra 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service License 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ dder Lance disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be Was case referred to medical 26. Place of Death (Check only one) 2 No 1 Yes Other: 4 Nursing Home 5 A Residence 6 Other (Specify ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d Describe how injury occurred 1. Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of 29b. Signatury 29c. License number 29d. Date signed (Month, Day, Year) 1/2 212

State Registrar

DHMH 17 Rev 06-2011

(0)

O. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Z003

32. Registrar's Signature

0500

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / De	epartment of Health and N Certificate of Death	/lental Hygie		18322				
	Physicia		Decedent's Name (First, Middle, Last)     Sylvia Weeks		2. Date of Death	Day 20 12	3. Time of Death  M				
	Medic Examin		4a. Facility Name (if not institution, give street and number)  Doctor's Hospital	4b. City, Town, or Location of Death  Lanham							
	Funeral Director		5. Social Security Number 578-24-4459  Usual Residence of Decedent  6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 14,	ar) Country	·				
	Maryland 28a-f shov otified at	Director	MD Prince George's Mitche		d. Inside City Limits 1 ☐ Yes 2 🍱 No						
	with the s 23a or ust be r	Funeral D	10e. Street and Number 10450 Lottsford Rd., Apt. 130	10f. Zip Code 20721	10g.	. Citizen of What Countr USA	y?				
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1  Never Married 2  Married  3  Noidowed 4  Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1  Yes 2  No  If Yes, Give Year or Dates.	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Americal Black, White, et Specify: White	c.				
Baltimore, Maryland 21215-0036	rithin 72 hou lene. r than "natu the Medical	Completed	(Specify only highest grade completed) (College (1-4 or 5+)	ecedent's Usual Occupation Give kind of work done during most of work re. DO NOT use retired) Memaker	Own Home						
yland 2	ld be filed w Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last)  Samuel Elmo Peake  18. Mother's Name (First, Middle, Malden Surname) Pearl Hilda Krauch								
Mar	d 2 shou alth and 27 is m er traum		17	Mailing Address (Street and Number or Rur 00 Merrydale Dr.,	al Route Number, Cit <sub>.</sub> Upper Marl		ode) 20772				
imore,	Page 1 and ment of Hea ant: If item ury or othe		1 X Burial 2 Compation 2 Removal from State Cemetery,	rans Cemetery 5/23	/2012 CH	c.Location - City or Towneltenham,					
Balt	permit. Depart Import any inj once,		21. Signature of runeral Sociote I censee	22. Name and Address of Facility Pe 6512 NW Crain Hw		al Home ie, MD 207	15				
area.	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)	enter the mode of dying, such as cardiac  Heart failure		11	Approximate Interval Between Onset and Death				
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):								
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ente, Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
200	ath certificate be executed attending physician and for use as the burial-transit		d.	· · · · · · · · · · · · · · · · · · ·							
Box 68760	de de	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	y Day Year				
ds, P.O.	To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the accompletely filled in by the funeral director, page 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in	2 No 3 Proba							
Division of Vital Records,	The law rectate has bee page 2 sho	Completed			24a. Was an autopsy performed 1 Yes 2	prior to com	sy findings available upletion of cause of				
Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1 Inpatient 2 ER/Outp	26. Place of Death (Checo		e 6 Other (Specify)					
on of \	nding Phy ath. r: After this	Certificate: T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation  28a. Date of injury (Month, Day, Year) injury	ne of 28c. Injury at	28d. Describe how i						
Division	ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director: After th pletely filled in by the funeral		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 3 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 Certifying Nurse Practitioner: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 1 Certifying Physician: To the best	investigation, in my opinion, death occurred a	at the time, date and p	lace, and due to the caus	se(s) and manner stated.				
	Total		29b. Signature and title of certifier  Daniel Olepane	29c. License number D 52815	•	Date signed (Month, D.	12				
(	THID		30. Name and address of person who completed cause of death (Item 23a) (Ty ) Inc. Hexanger, 12706 (5000)	pe, Print) 0 7	Bowie	MD. 20120	D				
	Sta Registr		31. Date filed (Month, Day, Year)  NAY 2 2 2012  32. Registrar's Signature	back		70					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month May Physician/ 18 Day 2012 12:05A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severna Park Center Severna Park Anne Arundel . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** sept Day 1 □ M 2X F Min. <sup>ea</sup> 1922 Maryland 89 216-22-3171 Director Usual Residence of Decedent f show Department of Health and Mental Hygiene. Incorporation of thems 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Trappe Talbot 1 ☐ Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3819 Seymour Dr. 21673 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 6th College (1-4 or 5+) Child Care Provider Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Day Louise Day 21113 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8603 Wintergreen Ct. Unit 307 Odenton, Carolyn Colvin(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metro Crematory 1 ☐ Burial 2 [X Cremation 3 ☐ Removal from State 5-21-12 Baltimore, Md. 4 Donation 5 Other (Specify) Mmame aRcaciseof AcilitSons Mortuary, 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ law disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate funeral director, pag 1 Yes 2 No 1 ☐ Yes 2 🛣 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🗶 No Hospital Other: ု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

n 24 hours after death.

e Funeral Director: After the leted filled in by the funeral Hospital To the Hosp within 24 hou To the Fune completed fi

Date filed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

18,3013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GRACE Year Physician/ LER MAN 0720M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ocial Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 280-48-6528 Hours **Director** 1 M 2XX 64 1/16/1948 OH Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Anne Arundel Millersville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be a by Funeral USA 1302 Alta Vista DR. 21108 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 married 1 Yes 24 X No Baltimore, Maryland 21215-0036 White 1 Yes XX No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Personal Assistant Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Iacullo Michelina Monaco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Wetterman Husband 1302 Alta Vista Drive Millersville , MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KMBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 5/24/2012 Crownsville, MD 21. Signature of Euneral Service Lives 22. Name and Address of Facility Hardesty Funeral Home, P.A. Tall 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons t and Death Immediate Cause (Final Proviolan/ DIFFUSE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed After this certificate 2 🗌 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? after death. 1 Yes 2 🗌 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of cartifier aw

Registrar

DHMH 17 Rev 06-2011

State

MAY 22 2012

T			Plea	ase Type or Pr					-		_		
OWNERE			For State	State of N	/laryland	/ Departme			Mental Hy	_	201	2 1	8325
3			Registrar  1. Decedent's Name (First, Middle)	e, Last)		Certifica	te or t	Jeain	2. Date of De	Reg. N	o. 2UI	- 1	of Death
100	Physicia Medic		JOHN W	IESI.EY	WI	CULLA	MS		Month	13	ay 2013	0	5PM
2	Examin		4a. Facility Name (if not institution	-		-	y, Town, o	r Location of Deat	<b>\</b>		c. County of Dea	th	
1	Funeral		VAMARY LAND 5. Social Security Number	6. Sex 7. A	ge (In yrs. las	10.00	er 1 Year	If Under 24 Hrs Hours Min.	8. Date of Bir	rth	9. Bir	thplace (State	e or Foreign
14	Director		185-42-3945 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	60	Yrs.	Days	Hours Will.	1/17	/52	PA	untry)	
TUTAMS	land show dat	tor	10a. State 10b. County		10c. City,	Town or Location						10d. Inside	
3	e Mary r 28a-1 notifie	Direc	PA PIII I	adelphia ————	Phi	ladelph	ia ip Code			100.0	Ditizen of What C		∕es 2 □ No
CAPA	n with th	Funeral Director	5019 N. Sme	dley St.				19141			USA	Juliuy.	
15:4 36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 ☐ Ma</li> <li>3 ☐ Widowed 4</li></ul>	1657	?	If Yes, spe	ecify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	-	14. Race - Ame Black, Whit Specify: B1	e. etc.	
5-00	2 hours "natur dical I	plete	15, Decede	ent's Education est grade completed)		16a. Decedent's Us (Give kind of w	ual Occup	pation during most of wo	rking	1	Kind of Business		
VAME KNOWS +OPHYS Baltimore, Maryland 21215-0036	rithin 73 iene. r than the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DO NOT u	se retired)	labor	, and the second	in	dustri	al	
DI S	filed wall Hyg d othe		17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maider	n Surname)		
NOW!	uld be d Ment marke natic	To.	John Wesley  19a. Informant's Name/Relations		Jr	19b. Mailing Addre	/044		Keith		- Taura Ctata 7	in Code)	
Ma	d 2 sho alth an 1 27 is er trau		Jurea_Willia		r	1018 W							
E ore,	ie 1 and t of He If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	-	20b. Pla	ice of Disposition (Na	ame of other pla	ce)	Date	20c. l	Location - City o	Town, State	
E Z	nit. Pag artment ortant: injury	1	4 ☐ Donation 5 ☐ Other (	Specify)	Was	hington		ssing 5					40 520
Zea	permit Depar Impor any in		21. Signature of Furiers					Smith F			rtown,		320
			23a. Part 1. Enter the disease, of shock, or heart failure. List	only one cause on each li	ne.				or respiratory a	rrest,		Approxin Interval E Onset ar	Between
ā	Physician/ Medical	3 1	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	O KE	RECU	RRE	TIN				unk	
	Examiner	_	Sequentially list conditions,			ENSIO	い						
	ped sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or a	s a conseque	nce of):							
	executed an and rial-transi	_	that initiated events resulting in death) Last	C. Due to (or a	s a conseque	nce of):							
09,	ate be physicia the bur	dica		d									
68760	ath certificate be executed attending physician and for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnan	cy					23d. Date of de	elivery	1
Вох	death the atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🗀 Live Birth 4 🗀 Pregnant 9 🗀 Unknown	at time of de			cy			Month	Day	Year
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant condit	ons contributing to death	but not resul	ting in the underlying	g cause g	iven in Part I.	23e. Did	tobacco	use contribute t	o the cause o	f death?
	quires sen sign			*					1 🗆	Yes 2	2 □ No 3 □ F		
ecol	law re has be	Completed							perf	opsy formed?	prior to death?	utopsy finding completion o	gs available of cause of
al R	Physician: The law this certificate has al director, page 2 a	Be Co	25. Was case referred to medica	74			26. P	lace of Death (Che	1 🗆 Yes eck only one)	2 🗷 1	No 1 ☐ Ye	s 2 No	
Vit	hysici this cer al direc	은	examiner?			R/Outpatient 3 🗆		4 Nursing			6 Other (Spe	cify)	
n of	nding F th. : After 1	cate	27. Manner of Death  1 Natural 5 □ Pend 2 □ Accident Invest	28a. Date of ir (Month, E	Jay, Year)	R8b. Time of injury	28c. Inju wor 1 🗔	ryat k? ]Yes 2 □ No	28d. Describe	how inju	ury occurred		
Division of Vital Records,	or Atter after dec Director in by the	Certificate:	3 Suicide 6 Could	not be 28e. Place of I	njury - At hom etc. (Specify)	ne, farm, street, facto	ory, office		28f. Location ( City or To		and Number or Re te)	ıral Route Nu	mber,
Q	Hospit 24 hour Funera	Medical	(Check 2 Medical	g Physician: To the best Examiner: On the basis o	examination :	and/or investigation, i	n my opin	ion, death occurred	at the time, date	and place	ce, and due to the	cause(s) and	manner stated.
	To the within 2 To the comple	Ň	only one) 3 L Certifyin 29b. Signature and title of certifie	g Nurse Practioner: To the	ne best of my l			ne time, date and p se number	lace, and due to t		e(s) and manner a Pate signed <i>(Mon</i>		
			Shen 9	t blash	me	MU	03	4648		M	1A4 13	,201	2
MS	+		30. Name and address of person			23a) (Type, Print)	eal+	h CAre S	45tem. P	e.Dv	ey Paint	Moa	4902
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regi	rar's Signatu	re 1. Spar	Ke )		J= 1-11		J ******	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.Pt.1.28d.28f.per.me.g928 6-25-12.sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OS Physician/ Vear Williams Donald Edwin 215 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** RAGIONAL MEDICAL NICOMICO 544156419 TENINGULA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min 220-54-1444 Director 1 X M 2 - F 59 07/14/1952 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Fruitland Maryland Wicomico 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21826 with 5286 Joy Row Lane items death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o 2 should be filed within 72 hours arrend thand Mental Hygiene.

27 is marked other than "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Entrepreneur Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Loretta Pickeral James H. Williams traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gary P. Williams/Brother 1735 Riverside Dr., Salisbury, MD 21801 3altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Shad Point Cemetery 5/24/2012 Salisbury, MD 4 Donation 5 Other (Specify) Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between shoteun wound to chest Onset and Death Immediate Cause (Final Physician/ SEIF inflicted disease or condition Medical resulting in death) consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the ail 1 Yes 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performe certificate 1 \sum Yes 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, 27. Manner of Death 28d. Describe how injury occurred subject t shot self 28b. Time of Certificate: 28c. Injury at eral Director: After filled in by the funer 1 🗌 Natural 5  $\square$  Pending work within 24 hours after death.

To the Funeral Director: Al 1400 1 Yes 2 No 2/12/12 ☐ Accident Suicide Investigation 6 Could not be ocation (Street and Number or Rural Route Number, 5286 by or Town, State) 5286 Joy Row Law, Frut land MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Residence Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier rpletely (Check only one) 3 Certifying Nurse Practitioner: To the best of my kno edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and 29c. License number 29b. Signadure and tit 29d. Date signed (Month, Day, Year)

30TC

State Registrar WaltER

31. Date filed (Month, Day, Year)

MAY

LISCHICK

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

4 2012

CHRIS

SNYDER

. Registrar's Signature

**#**50497

100 E Carrell St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Montto Physician/ Pearlie W. Wheatley 10:05 AM Medical Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death eastal Sbun Wrom voice at If Under 1 Year | If Under 24 Hrs 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 36-46-2921 1 □ M 2 X F 80 2-17-1932 West Virginia permit. Pege 1 and 2 should be flied within 72 hours efter deeth with the Meryland Department of Heelih and Mentei Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 26 Martinique Circle USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give چ Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates Partie Wheather 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Candy Kitchen Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Walter Harmon Pansy Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Graham Avenue, Berlin, MD 21811 William Wheatley/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 5-25-2012 Dover, DE Cremation, Bennie Smith W. Isabella St. 21. Signature of Funeral Service Licensee Home Salisbury, Funeral MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Break raiona Physician/ Can Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami certificete hes been signed by the ettending physicien end lirector, page 2 should be deteched for use es the buriei-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical . Hospital or Attending Physician: The lew requires thet the deeth certificete be to a hours efter deeth.

24 hours efter deeth.

Funeral Director: After this certificete hes been signed by the ettending physicia etely filled in by the funerel director, pege 2 should be deteched for use es the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 3. No Other (Specify) Ho မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ak 4.1 Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🔲 Yes 1 Natural 2 🗌 No 2 Accident Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hound to the second 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifie 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) D 63199 201,2

Registrar
DHMH 17 Rev 06-2011

State

YOGESH

31. Date filed (Month, Day, Year)

sarka

EASTERN

32. Registrar's Signatury

SHORE DR. SALISBURY,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOHRA 910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death May 24, Physician/ Candace Lou WEAVER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 11151 Lakeside Drive Hagerstown 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** April 16,1953 1 □ M 2 🕱 F 59 Maryland 219-60-4528 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director notified 28a-f Hagerstown 1 Yes 2 No Maryland Washington 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 5 pe U.S.A. 21740 11151 Lakeside Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0. 1 X Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify "natural" 3 - Widowed 4 - Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) hospital register nurse other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ Betty Lou Gladhill Donald Eugene Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Thicket Drive, McKinney, Texas Health tem 27 Donald J. Weaver - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of P Important: If ite any injury or ot once. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State May 39012 Big Pool, Maryland Park Head Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 2. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a co, soque, ec of, use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes 2 ♥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Mesidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Norse Practioner: To the best of my knowledge, d 29b. Signature app erson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

1136 OPAL CT HATE EIGSTUWN MD 21740

Baltimore, Maryland 21215-0036

Physician **Examiner** 

Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Records, Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene											10220				
			Registrar  1. Decedent's Name (First, Mid	idle I ast)		Cer	tificate of I	Death	Т		Reg. No. 4	16	10323		
	Physicia Medi		Paul	C. Wil.						2. Date of Dea Month 5	Day 4	Year	3. Time of Death  0 650 M		
,	Examir	ner	4a. Facility Name (if not instituti	_			4b. City, Town, or Location of Death  4c. County of Death  Wicomico								
-	Funeral	-	Peninsula Rec 5. Social Security Number	fional Media 6. Sex 7.	Age (In yrs. Is	ast birthday)	If Under 1 Year	li Sou	9. Birthplace (State or Foreign						
	Director		085-24-3958			RO Yrs.	Months Days	Hours	Min.	(Month, Day, Year) Country)					
	nd Tow	٦	Usual Residence of Decedent 10a. State 10b. Coun			v. Town or Lo	eation			Nov. 15	, 1931		y york		
	arylar a-f sl	ecto		rcester	_		1 42						0d. Inside City Limits  1 X Yes 2 No		
	or 28 e not	ä	10e. Street and Number	rasiei		<u>scom</u>	OKE Cit	7		Т	10g. Citizen of V	Vhat Count			
	s 23a ust b	Funeral Director	409 Linder	n Avenue	Apt.	101	218	351			นเร		.,,		
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at		11. Marital Status	12. Was Decede Armed Force	s?	3. 13. V	Vas Decedent of H	lispanic Orig	gin? (Speci	fy Yes or No- can, etc.)		e - America k, White, e			
336	al", o	d by	1 ☐ Never Married 2 ☐ M 3 🌠 Widowed 4 ☐ Divorc	If Van Civa	2		☐ Yes 2 🕱 No				Specify:	-			
21215-0036	hours natur dical I	Completed	15. Deced	dent's Education	5. *	16a. Deced	ent's Usual Occup	oation		1	16b. Kind of Bu	b. Kind of Business/Industry			
21	nin 72 ne. han " e Med	l E	Elementary/Secondary (0-12	chest grade completed) 2) College (1-4 of	or 5+)	life. DO	ind of work done O NOT use retired)		t of working	'	10-1				
	led within Hygiene.  other thar ent, the M	Be C	17. Father's Name (First, Middle	, tooth		7	ruck D					duce Hauling			
Maryland	ontal sed cev	10	John	Wilson				١		First, Middle, I	Maiden Surname	)			
ary	should be fill and Mental is marked ( aumatic eve		19a. Informant's Name/Relation			19b. Mailin	g Address (Street		_			tate. Zip Ci	ode)		
			Franscenia	Dungee		409							D. 21851		
ore			20a. Method of Disposition 1   ■ Burial 2   □ Crematic	on 3  Bemoval from St		lace of Dispo: emetery, crem	sition (Name of natory or other place	201	Da	te	20c. Location -	City or Tov	vn, State		
Baltimore,	t. Pag tmer tant jury		4 Donation 5 Other	(Specify)	Un		tist Chui						4. 23347		
Ba	permi Depar Impor any in	, ,	21. Signature of Funeral Service	milen			Name and Addre						eral Home		
				or complications that caust only one cause on each	sed the death line.	n. Do not ente	r the mode of dyin	ig, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between		
	nysician/ Medical	7	Immediate Cause (Final disease or condition resulting in death)	a. Pro	rumo	nig	and	Sep	513			- 10	Onset and Death		
	Examiner		3	Due to (or a	as a consequ	ence of):	Ca	10.50	7						
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or e	se a consequ	ianea-cry:	<u> </u>	W ( CD	-						
	hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	C											
	te be executed nysician and he burial-transi	alE	resulting in death) Last	Due to (or a	as a consequ	ence of):									
	cate b physi s the b	edical		d				-							
687	requires that the death certifica been signed by the attending ph should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon							23d Dat	e of deliver			
Box	death he atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birt 4 Pregnan	t at time of d		Ectopic pregnant Other (specify)	СУ			Mor		y Day Year		
P.O.	it the	Phy	9 Unknown	g ∐ Unknow						1					
σ.	The law requires that the rate has been signed by the page 2 should be detach	à	Part II. Other significant condi	lions contributing to death	n but not rest	aiting in the ur	iderlying cause giv	en in Part I.					cause of death?		
rds	requir been s	etec											ably 4 🗹 Unknown		
ecc	e law e has age 2	Completed								24a. Was a autops perfori	у р		sy findings available pletion of cause of		
<u>е</u>	sician: The certificate rector, pag		25. Was case referred to medica	al I			26. Pl	ace of Deatl	h (Check or	1 Tyes		☐ Yes 2	No		
Z Z	Physici this cer rat direc	10 B	examiner? 1 Yes 2 No	Hospital:	atient 2 🗆 I	ER/Outpatient	Oth	er:			nce 6 🗆 Othe	(Specify)	- 1		
ol	ing Pt		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of in (Month, L	njury D <i>ay, Year)</i>	28b. Time of injury	28c. Injury work	/ at			w injury occurre				
ioi	l or Attending after death. Director: After I in by the fune	Certificate:	2 Accident Inves	tigation d not be			M 1 🗆	Yes 2 🗌	No						
Division of Vital Records,	ital or A		4  Homicide deter	mined 28e. Place of I building,	injury - At hor etc. (Specify)	ne, farm, stre	et, factory, office		28	f. Location (Sta City or Town	reet and Number , State)	r or Rural F	oute Number,		
:	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 $\square$ Medical	ng Physician: To the best Examiner: On the basis on ng Nurse Practitioner: To	f examination	and/or investi	gation, in my opinic	on, death occ	curred at the	e time, date an	d place, and due	to the caus	e(s) and manner stated		
_ ;	Vith Vith Com		29b. Signature and tile of certifi				29c. License		,		9d. Date signed	(Month, Da	ıy, Year)		
							07	2494			5. 1	4. 1	2		
C	Tat		30. Name and address of person  Motor  T	n who completed cause of Saibars	100	E Car	roll Stra	ect S	Salis	bury n	15 an	801			
	Stat		31. Date filed (Month, Day, Year)	32. Regis			41								
	Registra		MAI	J 6016 / Bust	m f	1. pa	ver								

			For Amend Item : State Registrar		ryj <b>928 / 66/6</b> <i>Cei</i>	8/2012dhi rtificate of	Death		Reg. No. 2	112	18330		
Н	Physici		1. Decedent's Name (First, Middle, Las RUSSELL THOMAS	WADDELL,	SR.			2. Date of De Month MAY	ath BO 2012	Year	3. Time of Death 7:50 a M		
-	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			ty of Death	7.50 a		
ne policie			Hospice of Queer		//	Centrev	rille	Doto of Bir		en Anr	ne's place (State or Foreign		
Ŀ	Funeral Director		5. Social Security Number 167–30–3931  Usual Residence of Decedent	ex 7. Age	75 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da March 2	29 1937	Cour	ntry)  Name  Name		
	yland how		10a. State 10b. County		10c. City, Town or Lo	cation		·		1	0d. Inside City Limits		
	e Mar 3a-f s	Director	MD Queen Ar	ıne's	Millington						1 ☐ Yes 2 📉No		
	th with th	al Dire	10e. Street and Number 312 Perry Lynch	Rd.		10f. Zip Code 21651			U.S.A		ntry?		
36	I within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show the Widdel Evan her must be notified at	by Funeral	11, Marital Status  1 Never Married 2X Married	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give	№ 1957	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🙀 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra	ace - Americ lack, White, hify: Wh			
21215-0036		Completed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed (Specify only highest gra	Year or Dates: lucation de completed)	16a. Dece	dent's Usual Occup	oation during most of work d)	ing	16b. Kind of I				
212	filed within Hygiene. Other than '	omo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	e Operato			Steel	Mills			
and	be deve	To Be C	17. Father's Name (First, Middle, Last) David Frank Wadd				18. Mother's Nam Gertrud						
Maryland	271	-	19a. Informant's Name/Relationship (19ary Waddell	Type. Print) (wife		ng Address (Street Perry Ly	and Number or Ru	ral Route Numb Milling					
Baltimore,	of He		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other Specify		20b. Place of Dispo cemetery, cree Kent Cren	natory or other plac	ce) ¦	Date 4/12					
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Flur eral Servi	see	M00510 1	Name and Addre	ess of Facility neral Hom Cross St.	e of St	ephen I	. Sch	aech		
			3a. Part Enter the disease, or companies of companies of the shock, or heart failure. List only	plications that caused	the death. Do not en					.1033	Approximate Interval Between		
	Physician /Medical		Immediate Cau (Final disease or condition resulting meath)		STUE HILL	- I FA	tire				Onset and Death		
100	Examiner			Due to (or as a	a consequence of):								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):								
0,	ificate be executed g physician and ts the burial-transit	Exar	that initiated events resulting in death) Last	C Due to (or as a	a consequence of):								
68760,	cate be physici the bu	edical		d									
O. Box	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	cy		3.3	Date of deliv Month	very Day Year		
rds, P.	quires that in signed build be deta	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause giv	ven in Part I.		tobacco use co Yes 2 ☐ No		the cause of death?		
of Vital Records,		Completed								b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of		
/ita	slcian: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea		one)				
of \	this al dii	은	1 ☐ Yes 2 📉 No  27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie		4 🗀 Nursing n		idence 6 🔀	- ' '	ity) Happine Cop		
	ling After	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Wor	k? lYes 2□No	Zou. Describe	now injury occ	uned			
Division	il or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location City or To	(Street and Nur wn, State)	mber or Rur	ral Route Number,		
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical C			of my knowledge, dea f examination and/or in ated.								
	To the To the comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sig				
			1//			1067	5747		5/	4/ H	205/30/2012		
	3+1		30. Now and address of person who						04.51=				
	ノロ Sta	te	Jeffrey Ukens, 1 31. Date filed (Month, Day, Year) JUN 0 8 20	M.D. 2540	Centrevil ar's Signature	re Rd. (	Centrevil	Le, MD.	21617				
	Regist	ar	JUN U 8 20	116 Cerum	U B. 190	Wes							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Sara Dunning Zenge 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington County If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 19<u>14</u> 1 🗆 M 2 💢 F IIIinois 338-20-7790 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Washington Co. Hagerstown 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21740 1158 Luther Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Deceue... Armed Forces? Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2XXNo Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4XXDivorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Board of Education Director of Curriculum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Maisie Isler Henry Dunning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Yoakum Parkway, Alexandria, Virginia 22304 Judy Z. Grumbacher/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Smithsburg Crematory May 29,2012 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Eastern Blvd. North, Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days Physician/ pneumococia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner day s neumon. Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No as been signed by the a Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page performed' 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending after death. Director: Af 1 🗌 Yes 2 🗌 No Investigation Accident the □ Acciden
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie N MD

Registrar

09

Hugerstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

1138

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Adelesmatpanah Rajab June 0 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8 Date of Birth 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) **Director** 651-01-8885 1 🔯 M 2 🗆 F 85 09 30 26 Iran 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No CO NA Denver 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 380 Forest Street 08220 Iran death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify. "natural", Specify: Completed 3X Widowed 4 □ Divorced White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade United Nations Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Kolsoom Marhoum Karbalaei-Sadegh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Mary Lavoie-Daughter Forest Street, Denver, CO 80220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/15/2012 Behesht-Zahra Tehran, Iran 22.Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) e to (or as a consequence o Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by i Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page certificate 2 🗆 No Yes 2 L 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral (

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 Orleans Street, Baltimore MP 21287 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012<sup>Year</sup> ANNA MAE BUETTNER JÜNE 10:00 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MIDDLE RIVER IVY HALL GERIATRIC CENTER If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral Director** 219-14-5462 1 □ M 2**X** F MARYLAND 1/14/1924 Yrs 88 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10c. City, Town or Location with the Maryland Director notified 1 ☐ Yes 2X No PERRY HALL BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 23a Funeral USA 21236 39 CEDARCONE COURT items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 1. Marital Status Examiner Armed Force Black, White, etc ò 1 Never Married 2 Married þ 2 XNo Maryland 21215-0036 hours after Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural" 3X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the RETAIL CONSULTANT 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MELVA P. BRAY other traumatic JAMES P. WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 si it of Health a: If item 27 i 1539 DOXBURY ROAD TOWSON, MD 21286 SUSAN LYNCH/NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Department o Important: If any injury or injury or 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 6/12/2012 BALTIMORE, MD Signature of Funeral Service Licensee MOO2.17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. aproportion of disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner acmount of Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 the as ding IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box ( 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month Day Year 5 Other (specify) Pregnant at time of death P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) or Attending Physician: Be examiner? Hospital Other: 1 Tyes 2 X No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural Accider work?
1 Yes 5 Pending n 24 hours after death.
e Funeral Director: Aft 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 3 [

20

State Registrar 29b. Signature and title of

32. Registar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Dav. Year)

mo 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:30p. Barksdale 06 2012 Elsie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Hanover 1628 Cheston Lane Unit If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** Days Months Hours Min. (Month, Day, Year) 1 □ M 2 🔀 67 Director 225-58-3162 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tifered 25 is marked other than "natural", or items 23a or 28a-f sho and tifered 25 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hanover 1 Yes 2X No Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral U.S.A. 21076 1628 Cheston Lane Unit L 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AT&T Company Information Technician 2yrs <u>12th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nettie B. Tann William Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210761628 Cheston Lane Unit L, Hanover, Michele Barksdale-Daughter Department of Health Important; If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State South Hampton South Hampton 4 Donation 5 Other (Specify) 5/16/2012 County, NC al Signature of Funeral Service Lice March F/H West 21215 Baltimore, Μđ 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) uear **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 4fter work? 1 X Natural injury 5 Pending s after death.

I Director: Aft
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled in within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 3 only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 12

Registrar

DHMH 17 Rev 7/2009

15

State

0710

31. Date filed (Month, Day, Year)

haetse

Columbia, MD 21044

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

DRIVE

#G020

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 BURRESS DAVID 10:40 pm Tune Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MURITIS MEDICAL CENTER WASHINGTON HAGER STOWN . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 229-72-3650 1 M 2 D F Director 62 VIRGINIA Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Completed by Funeral Director WASHINGTON ✓Yes 2 □ No MD It A GORSTOWN 10e. Street and Number ò 10g. Citizen of What Country 11 WEST BALTIMORE 23a 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc ori 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. 60V. plummer 10 TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည BURRESS Hiram HILL MARY MCGUIRE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) 11211 JEK DRIVE HAGORSTOWN, MD. 21742 27 KAREN BURRESS 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Important: If it any injury or o SMITHSBURO CREM, JUNE 10,2012 Smiths BURO MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. Home 21. Signature of Funeral Service Licensee Sung 2. 110 was south st frederick mo 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onsexand Peath very monia Physician/ disease or condition resulting in death) Medical Examiner RESPITORY DISTRESS STHOROME Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the atter Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Yes 2 CH 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 20059190 JUNE 4 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATPOG-BONNETE MA GERSTUM M TICOPACE MERITUS MEDICAL

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-04200 State of Maryland / Department of Health and Mental Hygiene Alec Rodney Brooks 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0110 hrs **Medical Examiner** June 3, 2012 **Brooks** Alec Rodney 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital STU Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 1966 Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director Country) 1X M 2 F 55 45 Yrs. 216-76-3605 06/29/<del>1956</del> MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 109 1 X Yes 2 No Glen Burnie Anne Arundel Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic eveot, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 201 Cherry Lane 21060USA Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Yeer or Dates: 3 Widowed 4 X Divorced Yes 2 X No specify: Specify: Black <u>&</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Private Company Home Improvement 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tareasa Brooks Nat-Lee Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 19a. Informant's Name/Relationship (Type, Print) 21144848 Stevenson Road Severn, Md. Price Glorita 20b. Place of Disposition (Name of cemetery, Baltimore, Regret, Pages 1 and Department of Healt Important: If item 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemeter 16/12/2012 Baltimore, Md. Donation 5 Other Specify. 5 21. Signature of Funeral Service Licensee Name and Address of Facility Estep Brothers Funeral Service, PA 1300 Eutaw Place, BAltimore, Md. 21217 Approximate Interval 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Medica Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical UNPENDED AMENDED #7,8,perFH,G928,6/11/2012,WS Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 1 Live birth Ectopic pregnancy Month Year Fetal death past 12 months? 4 Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed should b certificate has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 s performed? Yes 2 No 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be of Vital examiner? Other Nursing Home 5 Residence 6 Other DOA this 1 Yes 28a. Date of Injury (Month Day,Year) Jun 3, 2012 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject driver in auto auto collision 0030 hrs Natural Division 1 Yes 2 V No 5 Pending the, 24 hours after death Fuoeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Unit blk N. Martin Luther King Blvd, Baltimore, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 3, 2012 rassl. 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signatural State

DHMH 17 Rev 1/2001 OCME 2006

Registra

DOME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day / 2012 Physician/ 1124 AM dward Wayne 06 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bultimore City Baltimore, MD University of Manyland Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral Director** 1 X M 2 □ F 219-48-3105 6/25/48 Virginia Usual Residence of Decede 63 28a-f show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location "natural", or items 23a or 28a-f sho death with the Maryland Director 1 Yes 2 No Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21144 USA 1407 Georgia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🗷 No Specify If Yes, Give Specify Completed 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene If item 27 is marked other the or other traumatic event, the Truck Driver Trucking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Clara Bell Ingram William Jesse James Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Severn, Maryland 21144 1407 Georgia Avenue Trudy Ann Black 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1  $\bowtie$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Important: I any injury o Loudon Park Cemetery 6/13/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Septic shock disease or condition Medical resulting in death) 24 hr **Examiner** preumonia Sequentially list conditions, if any, leading to immediate cause, care Underlying Cause (Disease or injury Examine as the burial-transit ST elevation myocardial and that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? ate has page 2 s performe 1 ☐ Yes 2 X No Yes 2 N certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗆 Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? X Natural 5 Pending 2 🗀 No within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar

of person who completed cause of death (Item 23a) (Type, Print) Ny-Ying Lam

St, Baltimore, MD 225. Greene

31. Date filed (Month, Day, Year) 1 2012

29b. Signature and title of certifier

32. Registar's Sign

P27331

29d. Date signed (Month, Day, Year)

06/07/2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

uintin Butler		State of Maryland / 1- For State Registrar	Certificate o			201 Reg. No.	2   1833					
Physici ledical Exam		1. Decedent's Name (First, Middle,Last)			2. Date of De Month		3. Time of Death					
Jourour Exam	»	QUINTIN BUTLER  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of De	Month May 29, ath	2012 4c. County of Dea						
		University Hospital		Baltimore		N/A						
Funeral Director		5. Social Security Number 6. Sex 7. Age 220-02-0760 1 M 2 F	(In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours M	41	irth(MM/DD/YYYY) 9. 8 .1-1981 Fore						
yne		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ition			10d. Inside City Limits					
<b>A</b>	Ļ	MD. N/A	BALTIMO				1 X Yes 2 No					
Maryland 28a-f show d at once,	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?					
th the Maryland 23a or 28a-f sho notified at once,		443 E. 28th ST.		21218	İ	USA						
ath wit tems 2	uneral	11. Manital Status  1 X Never Married  2 Married  Armed Forces?		as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue		o- 14. Race - Ame White, etc.	rican Indian, 8lack,					
ter dez ", or i	ш	1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	No 1	Yes 2 No specify:		Specify: BLA	CV					
hours after death with the Maryland 'nstural', or items 23a or 28a-f she Examiner must be notified at once	d by	15. Decedent's Education (Specify only highest grade comp		nt's Usual Occupation (Give kind o		16b. Kind of 8usiness						
2	plete	Elementary/Secondary (0-12) College (1-4 or 5-	+)	nost of working life. DO NOT use r	etired)							
5-0036 led within 72 hours Hygiene. other than "natur	Completed	-120-	LABO		me (First Middle	HAUL] Maiden Surname)	ING .					
21 be fi ntal	Be	QUINTIN BUTLER VELARIE A. KELLAM										
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex-	ဥ	19a. Informant's Name/Relationship (Type, Print )  VELARIE KELLAM (MOTHER)	V 2	g Address (Street and Number of								
e, M I and 2 Health item 2		20a. Method/of Disposition	20b. Place of Dispos	E. 28th ST. BAL sition (Name of cemetery,	Date Date	20c. Location - City of						
TOF Pages ent of nt: If		1 Burial 2 Cremation 3 Removal from Stat		· · ·	8-2012	BALTIMORE,	MADVIAND					
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tra		21. Signar ure of Funeral Service Licensee JONATHAN	D. HIBNER	Name and Address of Facility RE	DD FUNER	RAL SERVICE	MARILAND					
	a K	23a. Paryl. Enter the disease, or complications that caused the	17 رـــ	21-27 N. MONROE	ST. BAI	TIMORE, MAR						
Physician . /Medical		failure. List only one cause on each line.		the mode of dying, such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval 8etween Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound  Due to (or as a consequence)				· · · · · · · · · · · · · · · · · · ·	Death					
	_	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence)		<del></del>								
	mine	cause. Enter Underlying Cause										
executed in and il - transit	Exa	events resulting in death) Last  Due to (or as a consequence of d.	uence of):									
60, Constant and the burst of transit	Medical Examiner	UNPENDED AMENDED										
760, ficate be g physici the buri	/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the			20-	23d. Date of deliver						
Box 6876 death certificate he attending phy dor use as the l	iciar	past 12 months?	me of dooth	etal death 3Ectopic preg ther (Specify)	nancy	Month I	Day Year					
be deat	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown  Part ii. Other significant conditions contributing to death to										
of Vital Records, P.O. ag Physician: The law requires that the After this certificate has been signed by meral director, page 2 should be deach	百	contributing to death t	out not resulting in the u	underlying cause given in Part I.	1	obacco use contribute to s 2 V No 3 Prot						
Vital Records, Physician: The law requires this certificate has been sign I director, page 2 should be	Completed				24a. Was	an 24b. Were au	itopsy findings available					
eco he law ute has	dmo				autor perfo 1 ✓ Yes	rmed? death?	completion of cause of					
al R	<b>o</b> l	25. Was case referred to medical		26.Place of Death (Chec		2 No 1 Ye	es 2 No					
F Vit	70 B	100 110	2 Z ER/Outpatient		ing Home 5	Residence 6 Other	c .					
Division of ppital or Attending Phous after death.  Bornal Director: After tilled in by the funeral		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Yea May 29, 2012	28b. Time of Ir 1228 hrs	njury 28c. Injury at Work?	28d. Describe Subject sho	how injury occurred t						
Division tal or Attendii rs after death. al Director: A led in by the fu	Certification:	2 Accident Investigation 28e Place of Injur	ry - At home, farm, stree	et, factory, office building, etc.	28f. Location (	Street and Number or Ru	ral Route Number City					
Div	3 Suicide 6 Could not be determined (Specify) curb											
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	Medical (											
F 3 F 8	₹	29b. Signature and title of certifier	_	29c. License number		29d. Date signed (Moi	nth, Day, Year)					
		W-NU -		O.C.M.E.		May 30, 2012						
3		<ol> <li>Name and address of person who completed cause of dea Donna M. Vincenti, MD Assistant Medica</li> </ol>		W. Baltimore Street, Balti	more, MD 21	223						
	ate	31. Date filed (Month, Day, Year)  JUN 1 1 2012  37. Registrar's	Signature Sark	1.1								
Regist	rar	JUN I = 6016 Klasen	D. Warr									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 ay 201 20 ar 10:03 AM Physician/ Porhe RONALD EDGAR BAKER, JR. Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and number Examiner Noshi 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday, **Funeral** Months Hours 0 4 onth, Day, Country) 213 70 5190 40 MD Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Pasadena 10f, Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Funeral 21122 U.S.A. Coralwood 131 Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Balu Ronald life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Delta Insulation 12 Installer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Linda Ann Whitaker Ronald Edgar Baker, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health and Important: If item 27 is m any injury or other traum Pasadena, MD 21122 Kimberly Coburn - Sister 960 Marthas Vineyard Ln Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 6/8/2012 Cedar Hill Cem Baltimore, 4 Donation 5 Other (Specify) Signature of eral eral eral eral eral 22. Name and Address of Facility GJ Gonce Funeral Home PA 21122 169 Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent e of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence off burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 □ No 3 □ Probably 4 🕅 Unknown 1 Tes Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has autopsy perforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2 Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 2 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 2 Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Z Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, **Examiner** or Location of Death 4c. County of Death Samaritan Saltimore N/A If Under 24 Hrs. . Age (In vrs. last birthday) If Unde 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min 245-30-0405 Director 1 - M 2 F Ñ. Carolina 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director r 28a-f sh notified MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? b pe 23a 2534 Garrett Ave. 21218 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ò 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎛 No Black 3 XVidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Mo 9th Grade College (1-4 or 5+) Care Giver Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sam Hester Katie Bolton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Diane Sykes(granddaughter) 2534 Garrett Ave., Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State KIng Mem. Park 06/09/12 4 Donation 5 Other (Specify) Baltimore, MD Josephadres of Brown Jr. 21. Signature of Funeral Service Licersee Funeral Home PA 2140 Ñ. Fulton Ave., Baltimore, MD 21217 Approximate Interval Between Onser and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the IE FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Who detached for Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available has autopsy perform prior to completion of cause of death? this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 🗔 No မ MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director; 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. hin 2 only one) 29b. Signature and titl 10 29d. Date signed (Month, Day, Year) 2 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death Reg. No 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death :40 M Physician/ Medical 4b. City, Town, or Location of Death ounty of Death 4a. Facility Name (if not institution, give street a Examiner More 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (I) **Funeral** 3/1/1928 84 218-22-8513 Maryland Director 1 M 2 Yrs or 28a-f show 10h County 10c. City. Town or Location 10d. Inside City Limits 10a. State notified at Director 1 X Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code the 10e. Street and Numbe must be 23a Funeral **USA** 21224 1536 Charlotte Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. White If Yes, Give Year or Dates "natural", 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) A&P Grocery Store ccountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Scurto G. Crocetti Vincent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other traconce. 207 S. Tremont Rd., Baltimore, MD. 21229 Jean Schmidt (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other plac 1 XBurial 2 Cremation 3 Removal from State akeview Memorial Grds 6/8/12 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant signed by the attendated for u 3 Fctopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy 1 Yes 2 No 1 ☐ Yes 2 🕨 25. Was case referred to medical 26. Place of Death (Check only one) director. Certificate: To Be 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d Describe how injury occurred iniury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier D22114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

1 2012

DRCHESS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene  $\angle$   $\cup$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2012 11:26 AM amphe Homer June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 66 Director ITGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at BAITIMORE Director 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? ō 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) marked other than TRANSportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OKN UNK ၀ 19a. Informant's Name/Relationship (Type. Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 WIFE 28 Arlene 27 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 Burial 2 Cremation 3 Removal from State BAHIMORE, 6-13-2012 4 Donation 5 Other (Specify) em. 21. Signature of Funeral Service Licensee Joseph N ax 263 5. CONKLING St. BAHO or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dise shock, or heart failer Approximate Interval Between Onset and Death List only one cause on each line. Immediate Cause (Fi ral disease or condition resulting in death) **Physician** 2515 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed hysician and the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Tes 2 No 3 Probably 24a: Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 28a. Date of Injury

(Month. Day Year) Director: After this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury death. 2 Accident 1 Tes 2 No filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) within 2 To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bach 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001 11595

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 1 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health ertificate of Death			18343
	Physicia	an/	1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	2. Date of Dea Month		3. Time of Death
_	Medi	cal	John Joseph Cress  4a. Facility Name (if not institution, give street and number)	1	June 7	7, 2012 Year	4:00 P M
المد	Examir	ner	106 E. Cherry Hill Rd.	4b. City, Town, or Location Reisters	stown	4c. County of Death Balti	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birt Min. (Month, Day Aug 2	9. Birti X Year) 930 Mar	hplace (State or Foreign Intry) Vland
	show at		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L.	ocation			10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Baltimore Reis	terstown			1 🗆 Yes 2 📆
4	an the	alD	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?
4	tems 2	Funeral	106 E. Cherry Hill Rd.  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21136 Was Decedent of Hispanic Ori	igin? (Specify Yes or No-	U.S.A	
21215-0036	permit. Fage 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inhordant: If time ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married XX Married 1 ☐ Yes 2 X No	If Yes, specify Cuban, Mexican  1 ☐ Yes XX No Specify.	n, Puerto Rican, etc.)	Black, White	
15-0	n "natu Nedica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during mos	at of working	16b. Kind of Business I	ndustry
212	within giene. er thar, the M		College (1-4 or 5+)	oo NOT use retired) air Supervi:	sor	Fuel Oil	Company
70	e nied stal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		er's Name (First, Middle, i	Maiden Surname)	
aryle	snould be Tik and Mental I 7 is marked o raumatic eve	_	Charles Cress  19a. Informant's Name/Relationship (Type, Print)  10b. Mail	ettner			
	and z sn Health au tem 27 is other trau		TOD. Wall	ing Address (Street and Number E. Cherry H:			
	it of He if item or oth		20a. Method of Disposition  20b. Place of Disposition  XXBurial 2 Cremation 3 Removal from State cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City or	
ltim	permit. Page Department o Important: If any injury or once,			/ 1 e W 2. Name and Address of Facility	6/12/12	Sykesvil	1e, MD
Ba	Depar Impor any in		Just for 1	2. Name and Address of Facility 1605 Reisters	vecknardt stown Rd. C	Funeral Ch Wings Mil	apel, P.A. 1s.MD21117
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as			Approximate Interval Between
PI	hysician/ Medical		disease or condition  disease or condition  a. Dilated C.	rial	Onset and Death		
ا تعمید	xaminer		Due to (or as a consequence of):	J .	Fibrilla	tion !	Gollon
7	t t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
xecute	al-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):	Se		4	
60 ate be e	attending physician and for use as the burial-transit	dical	d			_	
5876 ertificat	ding ph	/Мес	IF FEMALE:				
P.O. Box 687 that the death certifical	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	very Day Year
P.0	ned by	by Pt	Part II. Other significant conditions contributing to death but not resulting in the			bacco use contribute to	the cause of death?
Division of Vital Records, alor Attending Physician: The law requires	een sig	ted	BAPH with Urinary retention - s	Suprapubic	Catherer 1 Dx	es 2 🗆 No 3 🗆 Pro	obably 4 🗌 Unknown
e law r	has b	mple	Nephrolithiasis		24a. Was a autop:	sy prior to co	opsy findings available ompletion of cause of
<u>स</u> स	s certificate has birector, page 2 s	Be Co	Carotid Stenosis + CVA 25. Was case referred to medical		1 ☐ Yes		2 🗆 No
VIII	r this certifica ral director, p	은	examiner?  1  Yes 2  Hospital:  1  Inpatient 2  ER/Outpatie	nt 3 DOA Other: 4 NL	ursing Home 5 Reside	ence 6 Other (Specif	· · · · · · · · · · · · · · · · · · ·
	th. After t funera	cate:	27. Manner eath  1 satural 5 Pending (Month, Day, Year)  28b. Time o injury  28b. Time o	f 28c. Injury at work?  M 1 Yes 2		ow injury occurred	
/iSiO	er dea rector: by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str		28f. Location (St	reet and Number or Rura	il Route Number,
	ours aft eral Dil	Medical C	building, etc. (Specify)  29a. Certifier 1 Vertifying Physician: To the best of my knowledge death		City or Towr		
e Hos	se(s) and manner as stated by and manner as stated by and due to the case.	Lucolo) and manner stated					
To th	To the		only one 3 Certifying Nurse Practioner: To the best of my knowledge.  29b. Signature and title of certifier	2	9d. Date signed (Month,	Day, Year)	
	1/		VWilson	D00679	57	06.08.3	2012
	41		30, Name and address of person who completed cause of death (Item 23a) (Type, In Victor, a Wilson 2970 Dec 31. Date filed (Month, Day, Year) 32. She is Signature 3. 4.	erint) de Road	Finksbure	21048	
	Stat		31. Date filed (Month, Day, Year) 32.	20.4.9		75	
DUMU	Registra		JUN 1 1 2012 June S. A.	avres			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	ryland / Depa			Mental Hygi	iene	18344
		_]	Registrar	Cer	tificate of De	eath	2. Date of Death	9	3. Time of Death
	Physicia	n/	Decedent's Name (First, Middle, Last)     Lutrial C	otton				n 3, 2012 Year	1:55p M
	Medic Examin	_	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County of Dea	th timore
فحسب			Gilchrist Center for Hospice C  5. Social Security Number   6, Sex   7, Age		If Under 1 Year	Towson If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign
	Funeral Director		5. Social Security Number  212-58-6251  Usual Residence of Decedent  6. Sex  7. Age	(In yrs. last birthday)  59  Yrs.	Months Days	Hours Min.	(Month, Day, Aug 5,	Year) Co	puntry) MD
	land show d at	tor	10a. State 10b. County	10c. City, Town or Loc		andallstowi			10d. Inside City Limits  1 Yes 2 No
	· 28a-f	Director	MD Baltimore		10f. Zip Code	anualistowi		0g. Citizen of What C	
	vith the	eral [	3908 Brenbrook Drive		701. Zip 0000	21133		U.S	
.0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced  12. Was Decedent Evarmed Forces? 1  Yes 2 N If Yes, Give Year or Dates.	No I	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 1 No dent's Usual Occupat	, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Am Black, Whi Specify: <b>BI</b>	te, etc. ack
715	an "na Medic	mp	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5-	(Give I	kind of work done du O NOT use retired)	iring most of work	ing		
212	withir yaiene		12	"		ver			Trucking
land	be filed lental Hy rked oth ic even	To Be	17. Father's Name (First, Middle, Last)  John Cotton	Sr		18. Mother's Nam	ne (First, Middle, N Jua	nita Burton	
Mary	2 should lith and N 27 is ma r traumat		19a. Informant's Name/Relationship (Type, Print)  Denise Cotton		ng Address (Street ar Brenbrook D		al Route Number, dalistown,	City or Town, State, Z MD 21133	(ip Code)
Baltimore, Maryland 21215-0036	age 1 and ent of Heal nt: If item 3 y or other	: 5	20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place Memorial Park	Jun	Date 08, 2012	20c. Location - City of Baltimore	e, Maryland
Baltiı	permit. P Departm Importal any injul		21. Signature of Eureral Service Licensee	7	2. Name and Address Estep Bro 1300 Euta	of Facility thers Funera w Place Balti	I Service, P. more, Md 212	A. 217	
No.	we burial-trans t	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.		evker				Interval Between Onset and Death
Box 68760	death certifical	<u>  •</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown  3c. If yes, outcome c 1 ☐ Live Birth 4 ☐ Pregnant at g ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of o	delivery Day Year
s, P.O.	The law requires that the death rate has been signed by the atte page 2 should be detached for	by	Part II. Other significant conditions contributing to death be	ut not resulting in the I	underlying cause give	en in Part I.			to the cause of death?
of Vital Records,	The law require ate has been si page 2 should l	Completed						sy prior t med? death	autopsy findings available o completion of cause of ? Yes 2 \( \sum \) No
al R	ilcian; The certificate rector, pag	Be C	25. Was case referred to medical		26. Pla	ice of Death (Che		2 110	00 2 2 1 10
of Vit	S 0 0	ျ	examiner? 1  Yes 2 No Hospital: 1 Inpatie  27. Manns of Death 1 Natural 5 Pending (Month, Day		of 28c. Injury work	4		ence 6 Other (Sp ow injury occurred	ecity) Hespies
Division	al or Attending Ph. s after death. I Director, After thi ed in by the funeral	Certificate:	2 Accident Investigation	ury - At home, farm, st c. (Specify)		Yes 2 No	28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	ledical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practitioner: To the	vamination and/or inve	stigation, in my opinio	n. death occurred	at the time, date at	nd place, and due to th	e cause(s) and manner stated.
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		Type, Print)  29c. License number  D25205  Zype, Print)  6701 N. Charles St. Balto. Md				
	5		30. Name and address of person who completed cause of d	eath (Kem/23a) (Type,	Print) 6 70 1 A	! Char	les St.	Balto.	md 71204
	Sta Registr			ar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Dixon 2012<sup>ea</sup> June 9 2:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Larkin Chase Nursing & Rehab P.G. Bowie If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 93 Yrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M XXX (Month, Day, Year) 2-21-19 **Director** 223-12-8149 Danville, Va Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD. P.G. Bowie 1 X Yes 2 No 10e, Street and Numbe 10f. Zip Code r must be r 10g. Citizen of What Country? Funeral 15005 Health Center Drive 20716 U.S.A. death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ö 1 ☐ Yes 2**X** No If Yes, Give þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: "natural", Completed ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th Domestic Housewife event, Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant; if item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Berdie Edwards Annie H. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Benson/Son 7750 Burnside Road, Landover, Md. 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/12 Lincoln Memorial Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signi of Funeral Service License 2 Name and Address of Facility Hackett's Funeral Chapel, 814- Upshur Street, N.W. to w. 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Advanced Dementia years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical certificate be Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No
9 Unknown ò 5 Other (specify) Month Pregnant at time of death Dav Year detached the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Hypertension Records, 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy certificate 2**X** No 1 🗌 Yes 2 🗆 No Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: å 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 **X**No ဂ္ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred 1 X Natural 5 Pending injury death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 24 hours after death Funeral Director: Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6-11-12 00051437

State

Registrar

DHMH 17 Rev 7/2009

12200 Annapolis Rd. S-232 Glendale, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Sinature

Okeowo Ibitoye,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ukes maron 2054 Medical 4a. Facility Name (if not institution, give str 4b. City, Town, or Location of Death Examiner 4c. County of Death Montaomeru tolu ver prina **Funeral** . Age (In yrs. last birthday) If Under 8. Date of Birth Birthplace (State or Foreign 240-02-(Month, Day, Year, 1 □ M 2 🗗 F **Director** North Carolina Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 XYes 2 □ No monto meru 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a ( Funeral 20902 HRCO "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Black If Yes Give 3 Widowed 4 Divorced Specify: Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) WRITER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden S ည 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or R ral Route Number, City or Town, State, Zip Code) Stanton Lane Department of Health Important: If item 27 Helena 20b. Place of Disposition (Name of ō Burial 2 Cremation 3 - Removal from State injury o 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee EDITH WYNN FUNERAL SERVICE P.H any Baltmoremarylance 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Septic Phy idian Medical resulting in death) Examiner Neumonia Sequentially list conditions, it any leading to increase cause. Enter Underlying Examiner use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No ó Month Day should be detached 9 Unknown à Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? been signed þ 1 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform maestive Yes 2 X No this certificate 25. Was case r ferred to medical the funeral director. To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director; After 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910

Registrar
DHMH 17 Rev 06-2011

State

Detling Doug 195

				Please	Type or Pri							_		_	ible.		
			For State		State of M	arylan					and M	lental Hy			10	1.0	31.7
	-		Registrar  1. Decedent's Name	e (First Middle, Las	<i>it</i> )		Cer	tificat	e or L	eatn		2. Date of D	Reg. N	0./	1	2 Time	of Death
	Physicia				glas	Α.	De	tling	7			Month Day Year 2:1					
1	Medio Examir		4a. Facility Name (if		.'				-	Location	of Death						
	77.6		Frankl	in Squa	se Hosp		and the body and and		75ea	If Under	24 Ure	0 D-t(D)		3a1.			
	Funeral Director		5. Social Security No.		X) M 2 $\square$ F		ast birthday) Yrs.	If Unde Months	Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year)		Coun	ry)	e or Foreign
			Usual Residence	of Decedent	A 2	72						Feb.	3, 1	3, 1940   South Dakota			
	ryland -f sho ied at	ctol	10a. State	10b. County			y, Town or Lo								1		City Limits
	or 28a	Dir.	Maryland 10e. Street and Num	Baltimo	re		Baltim	ore 10f. Zij	o Code				10a. C	Citizen of V	Vhat Coun		163 2 24 110
	with the	Funeral Director	5118 M	cFaul Roa	d					206				U.S.			
	items items	ᇤ	11. Marital Status		12. Was Decedent	Ever in U.S	S. 13. \	Was Dece		_	igin? (Spe	cify Yes or No Rican, etc.)	-		e - Americ		-
36	after al", or xamil	d by	1 X Never Marr	ried 2 Married	Armed Forces?  1 ☐ Yes 2X  If Yes, Give	No		I ☐ Yes							Whit		
5-0036	hours natura lical E	Completed		15. Decedent's E	Year or Dates.		16a. Deced	dent's Usu	al Occupa	ation			16b.	Kind of Bu			
2121	nin 72 ne. <b>han</b> " e Mec	dwo	Elementary/Seco	ondary (0-12)	College (1-4 or	5+)	life. D	kind of wo O NOT us	e retired)			ng	C.		of Mo		d
2	Hygier Hygier other t	Be C	17. Father's Name (	First Middle Last)	2		Comput	er P	rogra			e (First, Middle		ate		Tyla	IIG
lan	be file ental i rked c	To I	Tr. Tautor 5 Harrio I		rad	De <b>tl</b> i	ing				oseph			stin		nder	son
Maryland	should be filed within 72 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med		19a. Informant's Na	ame/Relationship (T				ng Addres	s (Street a			l Route Numb					
Σ	nd 2 s ealth m 27		Julie		Niece					Terr	cace	Balti	_	<u> </u>			1206
lore	ge 1 a nt of H ; If ite or oth			Cremation 3	Removal from State		Place of Dispo cemetery, cren	natory or	other place			Date		Location -	•		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		_	5 Other (Special		Ga	rdens (	ot ta				2012 ick Tow		Ltimo			
Ba	permi Depar Impol any ir	- 1	A	14.10	Lagan			1050				owson,				1204	ino.
			23a. Part 1. Enter t shock, or hea	the disease, or com rt failure. List only o	plications that cause ne cause on each lin	d the deat e.	h. Do not ente	er the mod	de of dying	g, such as	cardiac o	r respiratory a	arrest,			Approxin Interval E	Between
	h, i i.n/		Immediate Cause (		a Respi	cat	V20	Ars	251	<u>.</u>						Onset an	nd Death
Sept.	Medical Examiner		resulting in death)	r	Due to (or as			. 1.	2011/03	22000	. 1.	us			. 1		
10		ner	Sequentially list co	nmediate III	b. Due to (or as	a consequ	espin	CATS	X	mus	LIC		OK	ness	•		
	s executed ian and urial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated event	injury		non											
	e exection a cian a curial-		resulting in death)	Last	Due to (or as	a consequ	uence of):										
68760	cate b physics the l	Physician/Medical			d												
68	ending use a	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, outcome			7 Ectonic	nregnanc	v			8	23d. Da	te of delive	ery	
Box	death he ath	sici	in the past 12 1  Yes 2  Unknown	□ No	4 Pregnant : 9 Unknown			Other (s	pecify)	,				Mo	nth	Day	Year
P.O.	at the ed by t detack	/ Ph			ontributing to death I	out not res	sulting in the u	ınderlying	cause giv	en in Part	1.	23e. Did	tobacco	use conti	ribute to th	e cause o	of death?
S, F	n signe	ed by										1 🗆	Yes 2	2 <b>V</b> No	3 🗆 Prof	ably 4	Unknown
orc	iw requ	plet										24a. Was	s an opsy	24b. \	Were autop	sy finding	gs available of cause of
Records,	The la ate ha page	Completed										_ per	formed?	ا ا	death? 1 🔲 Yes	•	
ita	ician: certific rector,	Be	25. Was case referrexaminer?		Hospital:				Othe	ar.	ath (Check						
of Vital	Phys r this eral di	e: To	27. Manner of Deat	h	28a. Date of inju	ury	ER/Outpatier 28b. Time of		OA   28c. Injury	4 ∐ N ≀at		me 5 🗌 Res 28d. Describe					
on (	anding eath. or: Afte	ficat	1 Natural 2 Accident	5 Pending Investigation		ıy, Year)	injury	М	work	? Yes 2 🗆	] No						
Division	or Atter fter de irrecto	Serti	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In building, et	ury - At ho c. <i>(Specif</i> )	ome, farm, str	eet, factor	y, office			28f. Location City or To			er or Rural	Route Nu	mber,
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the tuneral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b	Medical Certificate:	29a. Certifier 1	ertifying Phy	sician: To the best o	f my know	ledge, death	occurred a	at the time	date and	d place, ar	nd due to the	cause(s)	and mann	ner as stati	ed.	
	ne Hos n 24 h ne Fun pletely	Medi	(Check 2	Medical Exam	iner: On the basis of a se Practitioner: To the	examinatio	n and/or inves	tigation, in	my opinio	n, death o	occurred at	the time, date	and plac	ce, and due	e to the car	use(s) and	manner stated
	Vithi To th		29b. Signature and			MO		29	c. License	number			29d. D	ate signe	d (Month,	Day, Year)	
			-	-	zamova			6	Res	000	20		6	- 7 -	20	12	
0			, 1	ress of person who	completed cause of	death (Item	n 23a) (Type, F	rint)	260		× 70 = 1	.10 D =	11.	0.000	44	25	27
	Sta	te	31. Date filed (Mont	th, Day, Year	32. Registi	ar's Signa	ture		11 09	CICCI é	- DE1	<u>ve 60</u>	IT IN	juse	MI	<u> </u>	<b>\</b>
	Registr	ar	JU	M T T ZOIS	Contract	10.	7										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 6, 2012 10:40 am Dorothy Evans Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Cockeysville Masonic Home 8. Date of Birth (Month, Day, ) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** . Year) 9<u>14</u> 1 □ M 2 🖼 F Hours Days Mary Tand 98 212-01-1783 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Fallston 1 Yes 2 X No Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21047 USA 2510 Hess Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mueller Ida Hart John Beauregard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2510 Hess Rd., Fallston, MD. 21047 Nancy E. Turk (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 6/9/12 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3620 Wilkens Ave. Baltimore, 21. Signature of Funeral Service License 21229 Loudon Park Funeral Home 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 1 ☐ Yes 2 및 g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ in, COPD, GERD, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy 2 100 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ₩No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 2:10 PM Physician/ Emma Lee Evans 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAR FORD MEMORIAL HAURE 2-HARFORD 1405 P17AZ GRACE Hours Min. 8. Date of Birth (Month, Day, 09/24/ 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 □ M 2 🖾 F 87 243-32-4796 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Churchville 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Funeral 21028 items 23a 2614 Thorny Drive USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. Yes 2x No and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Restaurant Owner 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even once. မ Lizzie E.Shaw Ben Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21028 19a. Informant's Name/Relationship (Type, Print) 2614 Thorny Drive Churchville, Maryland Vanessa Briggs/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔯 Burial 2 🗆 Cremation 3 🗀 Removal from State Windsor Mill MD. 06/15/12 King Memorial Park 4 Donation 5 Other (Specify) ur Funeral Service Life ee <sup>22. Name and Address of Facility</sup>Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD.21215 Hour 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ SCESI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be emithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗌 Yes 2 ₩No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ATTONDING 20062239 3 m MAN NATING DO, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO GRAZE HOSPITAL Manuria 31. Date filed (Month, Day, Year 32. Registrar's Signature State 2012 Registrar

			Please Type or Print in Black In amend item I per doc g928 6- State of Maryland / Department	ndelible Ink. Ensure All Copic -11-12 vt artment of Health and Mental H	es Are Legible.
		•		tificate of Death	Reg. No. 2012 18350
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  George Earl	Frick 2. Date of I Month	Death Day Year 930 PM
	Examin	er	4a. Facility Name (if not institution, give street and number)  Genesis Eldercare	4b. City, Town, or Location of Death Severna Park	4c. County of Death Anne Arundel
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8. Date of E	Birth 9. Birthplace (State or Foreign
	Director		269 26 6535	Months Days Hours Min. 0900th	Pay, Year 30 Country) Ohio
	faryland 3a-f show tified at	ector	10a. State 10b. County 10c. City, Town or Lo MD Anne Arundel Pasaden		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	a or 28	al Dir	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath with	nner	2953 Rose Crown Circle  11 Marital Status 12. Was Decedent Ever in U.S. 13.	21122 Was Decedent of Hispanic Origin? (Specify Yes or No.)	U.S.A.
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, th∗ Medical Ex∗miner must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1 X Yes 2 No 1950 -	was becedent of Hispanic Origin? (specify fes of Ni f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No Specify:	14. Race - American Indian, Black, White, etc.  Specify: White
5-0	2 hour "natu edical	plete	15. Decedent's Education 16a. Decedent	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business Industry
21215-0036	within 7 giene. er than	Com	Elementary/Seconday (U-12) Uollege (1-4 or 5+)	ONOT use retired) Chasing Agent	Electronics
	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middl	e, Maiden Sumame)
ylaı	should be filed vand Mental Hyg rand marked othe ranmatic event,	욘	George A. Frick	Mary Mow	
Maryland	and 2 shou Health and tem 27 is n		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir Kathleen Mannion -daughter 2953	ng Address (Street and Number or Rural Route Numi Rose Crown Circle	ber, City or Town, State, Zip Code) Pasadena, MD 21122
Baltimore,	of Head of Head If item		20a. Method of Disposition 20b. Place of Dispo		20c. Location - City or Town, State
ţim	t. Page tment c rtant: If njury or		4 Donation 5 Other (Specify)  Bayview	Crematory 6/2/2012	Baltimore, MD
Bal	Depar Depar Impor any ir			.69 Riviera Drive P	e Funeral Home, PA asadena, MD 21122
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Sevel Anemicisease or condition		Approximate Interval Between Onset and Death
Seption	Medical Examiner		resulting in death)  Due to (or as a consequence of):		Eine
	d sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ustic Syndrome	2412
	execute ian and irial-trans	al Examiner	that initiated events c.  Due to (or as a consequence of):		
09,	ate be physici the bu	edica	d		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
P.0.	v requires that the der been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the L	underlying cause given in Part I. 23e. Dic	tobacco use contribute to the cause of death?
ďs,	equires sen sig ould b	ted	urinary tract intection	1	Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	Physician: The law re r this certificate has be aral director, page 2 sh	Comple	Diabetes Wellitos		opsy prior to completion of cause of death?
ital	ician: certific rector,	Be	25. Was case referred to medical examiner? 1   Yes 2   No	26. Place of Death (Check only one) Other:	
of V	ng Phys fter this ineral dii	te: To	27. Manner of Death  1 Inpatient 2 ER/Outpatier  28a. Date of injury (Month, Day, Year)  28b. Time of injury	nt 3 □ DOA 4 Nursing Home 5 □ Re	sidence 6 Other (Specify)
sion	Attendi death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	(Street and Number or Rural Route Number,
Divi	ital or / urs after ral Dire	al Cei	building, etc. (Specify)	City or To	own, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of t	tigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated.
	To t		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	5+1		30 Name and address of person who completed cause of death (Item 23a) (Type, F		Jule 1, 2012
	, ,			aint Rd Baltimore.	mb 21219
	Stat Registra		31. Date filed (Month, Day, Year) 1 2012 32 flegistrar's Signatur	arle	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 ear Physician/ Jennie Greene 4 2:30 рм June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Alice Manor Nursing Home Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Days Carolina Carolina Hours 214-22-2084 **Director** 1 □ M 2 🔀 F 91 04/01/1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified Maryland Baltimore 28a-f 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 1146 Gorsuch Avenue 21218 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Examiner Armed Force Black, White, etc. 6 þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give filed within 72 hours after altimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: Black "natural", Completed 3 ₩ Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Private Homes Elementary/Secondary (0-12) College (1-4 or 5+) the 5th grade Cook traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter Johnson Mamie Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau once. 1146 Gorsuch Avenue Baltimore MD. Dolores Thompson/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Arbutus, Maryland 06/08/12 Arbutus Mem.Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral 4210 Belair Road Baltimore MD.21206 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physican 100 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Diak requires that the death certificate be P.O. Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Joint Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law r 24 hours after death.
• Funeral Director: After this certificate has b page 2 autopsy performed Yes 2 No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31464

State

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

2012

32. Regionar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOALI3 A. HASHMI MD. 821 N. EYTAW ST SHIP 300 BALTIMORE MD 21261

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marcie Rita Healy 8, Day 2012 Year JUME 2:30 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 8. Date of Birth
(Month, Day, Year)
13,1921 Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 216-16-5671 Hours Director Maryland 90 1 M 2 KF should be filed within 72 mou...
and Mentel Hygiene.
7 is marked other than "natural", or items 23a or 28a-f anom7 is marked other than "natural", or items 23a or 28a-f anom7 is marked other than "natural", or items 2 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Carney 1 🗆 Yes 2 🗐 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3007 Fourth Avenue 21234 **USA**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by A D ( A A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) ( A D ) 1 Yes : 2 XNo white 1 Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker At Home permit. Pege 1 and 2 should be filed with Department of Health end Mentel Hygier Important: If item 27 is marked other tany injury or other traumetic event, Impones. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony J. Herman Agnes Ortt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co Marlene Hild-daughter 585 Riverside Drive-Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other p Pege 1 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 6-12-12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility vans Funeral Chapel and Cremation Services 800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ettending physicien end I for use es the burlei-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical / 什んししと 「アンカレリ Division of Vital Records P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Month or: After this certificete hes been signed by the the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 20 1 Tyes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending 2 Accident
3 Suicide Investigation 1 ☐ Yes 2 ☐ No М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ Ollie Juanita Haga June 6, 4:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Health Care Center Sykesville Carroll If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Days Hours Min. Dec. 19 1 - M 2XX 93 Virginia 1918 **Director** 218-22-8357 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 🏋 🕅 No MD Carrol1 Finksburg ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21048 U.S.A. 4152 Poole Rd. or items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify White Specify "natural", ¥Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment. Important. If item 27 is marked any injury or over. ည Dottie Ellen Vipperman Daniel Brown Odham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Poole Rd. Finksburg, MD 21048 <u>William Haqa</u> 4152 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Evergreen
Memorial Garde 1XX urial 2 Cremation 3 Removal from State Finksburg, MD 6/11/12 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Furley | Se y ce Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills,MD21117 23a. Part 1. Enter the disease, or complications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eightige. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, day, leading to in redicto cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for sein echecommench requires that the death certificate be executed and Due to (or as a consequence of): tending physician are r use as the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lunamo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy this certificate has page 2 Yes 2 No 1 Yes 2 INO 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital 1 🗆 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After work? 1 Yes 2 No injury "Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 20806

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Moni

ac 40 21131

ddress of person who completed cause of death (Item 23a) (Type, Prip

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 Month Physician/ Howard James Huhs 7:07A 9 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Country) 525-34-0093 Director 1 X M 2 □ F 86 6-23-1925 KS Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits with the Maryland 10a. State 10c. City. Town or Location notified at Director MD Carroll 1 X Yes 2 No Westminster 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9 must be n Funeral 22 Pennsylvania Ave., Apt A 21157 USA items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status er than "natural", or iten the Medical Examiner rmed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking 12 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ္ be Frank R. Huhs permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. Hazel L. Hyronynus traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Huhs-son Deerfoot Ct., The Woodlands, TX 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 6-11-12 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee 21157 Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause interval Between Onset and Death Immediate Cause (Final SCHEMIC CAROLOMY ONATHY Physician/ G PAR disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit ding physician and Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes been sig should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 this certificate has 1 Yes 2 No 25. Was case referred to medica examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) DENG C Hospital: 2 19 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After I injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 2<mark>9</mark>c. License number 29d. Date signed (Month, Day, Year) D31660 6/8/3012 Conco K. Golden & MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

195

32. Recistrar's Signature

THORAS K. GALVIN III MO

31. Date filed (Month, Day, Year)

1 2012

SIDNER NENDE WESTMUSIER MALYUND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 3 YOK 400 PM DANIEL AUGUSTUS HOWARD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY GENERAL HOSPITAL ONLEY MONTGOMERY 5. Social Security Number **Funeral** Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F (Month, Day, Year) 8-31-1916 Months Days Hours Min. Director Country)
MARYLAND 215-05-9727 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD. HOWARD COOKSVILLE 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2415 MILLERS MILL RD. 21723 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner 14. Race - American Indian Armed Forces 9 Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes. Give "natural", 3 ▼Widowed 4 □ Divorced Specify: BLACK Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation e filed win. خوا Hygiene. خوا **than** "r 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Should be filed with and Mental Hygien 7 is marked other the -7--0-MECHANICAL ENGINEER FARBORIAL PAINT CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 DANIEL H. HOWARD LOUISA PRETTYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) t and 2 single of Health ? NELLIE HOWARD (DAUGHTER) 2415 MILLERS MILL RD. COOKSVILLE, MARYLAND 21723 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 4 Donation 5 Other (Specify) CRESTLAWN CEMETERY 6-9-2012 MARRIOTTSVILLE, MARYLAND 21. Signat tre of Funeral Sur e Li ns JONATHAN HIBN: R2. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pant 1 Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Interval Betweer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or). cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): sician burial-Physician/Medical Division of Vital Records, P.O. Box 68760 phys attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Unknown g | Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? þ BSTRUCTIVE Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy page performed Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

0 State (Check

only one) 29b. Signature and title

30. Name and address o

31. Date filed (M

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

LOUTE 97

SUITE 10

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Dav Year Month 53 TLYTE Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Loch Raven Va Community Living & Baltimore N/A Rehabilitation Center 7. Age (In vrs. last hirthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1) 9. Birthplace (State or Foreign Country) Salem, S. Dakota **Funeral** Days 1 **X** M 2 □ F 219-12-9970 87 **Director** Sept. 1924 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland **Baltimore** Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America Funeral 612 Carvel Grove Road 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 XXYes 2 If Yes, Give Year or Dates 2 No white 1 ☐ Yes 2XXNo Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. Jarvis Lumber & life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Steel Company 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Ray Kirkendall Thelma Herreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jean Kirkendall/ wife 612 Carvel Grove Road Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 11, cemetery, crematory or other place)
Garrison Forest XBurial 2 Cremation 3 Removal from State 2012 4 Donation, 5 Other (Specify) Garrison, Maryland Cemetery 22. Name and Address of Facility
Peaceful Alternatives Funeral & Crematicn Center, P.A.
2325 York Road Timonium, Maryland 21093 Signature of Funeral Service License 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician sthe burial Physician/Medical attending p for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death the led by tl detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed prior to completion of cause of death? 1 ☐ Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard Dennis Kelty 2012 0639 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Andrus House Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours **Director** 144-24-5155 73 1 X M 2 □ F 6-15-1931 New Jersey permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31 Booth Steet #259 20878 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Guidance Councelor Education Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည John Earl Kelty Madeline Veronica Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Booth Street, #259, Gaithersburg, Maryland 20878 Sherri Kelty - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State National Crematory 4 Donation 5 Other (Specify) 6-5-2012 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Brad Smetzer 1170 Rockville Pike, ROckville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Prostate Cancer disease or condition resulting in death) Due to (or as a consequence of): Congestive Heart Failure

Physician Medical **Examiner** 

Baltimore, Maryland 21215-0036

show

ing physician and sas the burial-trans

attending physician for use as the buria

been signed by the a should be detached t

certificate be executed

Box 68760

P.O.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Failure to Thrive Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Parkinson's Disease 25. Was case referred to medica Be 1 ☐ Yes 2 X No ည 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpa 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of X Natural 5 Pending Certifical Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

23d. Date of delivery 3 Ectopic pregnancy Day Other (specify) Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Notice Specify Living

Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certified filled in by the funeral 24 hours Within 2 ١d

Medical

29b. Signature and ne of certifie www

XCertifying Physician:

D0071250

28c. Injury at

work

1 Yes

the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🗌 No

n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examinar. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 6-4-2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Ira Rosenman, MD - 5735 Balsam Grove Ct., Bethesda, Maryland 20852

31. Date filed (Month, Day, Year, JUN 1 1 2012 Registrar

29a. Certifier

(Check

only one

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8, per fh, g928 6-12-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** KELLY, JR. WILLIAM 05:45AM 06 2012 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRINTON WOODS OF FRANKFORD BALTIMORE SALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 89 Yrs. 214-20-7849 Usual Residence of Decedent Director 5/19/1923 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State Baltimore 1X Yes 2 No Funeral Director MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 N. LInwood 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Mes 2 No Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No 2 Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be Kansdell ဂ္ WILLIAM Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. LINWOOD AVE. KEUY MYRTLE WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 6/13/12 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Battimore, Md GARRISON Forest 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn GReene Fineral Survers MO1553 Balt, more, MO. 4212 YORK Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HRONTE UBSTRUCTEVE /Medical Due to (or as a consequence of): Examiner YPERCAPNIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) led by the a ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy ARDOMINAL AORTEC 2 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D0073354 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 WALTHAM WOODS RD #204 PARKUILL ARUN RAGHUNATH 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

JUN 1 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012Year **Physician** June<sup>th</sup> Jang S. Kang 5:15 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Health & Rehab Center Anne Arundel Marley Neck 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 219-27-2574 81 Director Korea Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Exacilist Funst be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 182 Virginia Lane, Apt.G 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 M Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: Korean þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Trading Company LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be th and Mental I Shin Hong Kang Sun Chul Jung 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 182 Virginia Lane, Apt. G, Glen Burnie, Maryland 21061 Jae Kang:Wife Injury or other permit. Pages 1 an Department of Heal Important: If item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation, Inc. 6-9-12 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael marzulle 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or cour claims that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an of Vital 1 □Yes 2 No 1 □Yes 2 **2**No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 3064-1 3 m 2012

Registrar DHMH 17 Rev 1/2001

State

201-109

32. Registrar's Signature

Back Rivernede Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapalhi

Ramesh

31. Date filed (Month, Day, Year)

			1 = For Amend Item 26 Registrar						lealth and i			201	2	18350	
			Decedent's Name (First, Middle, Last)				111100	-	Journ	2. Date of De		Ui	3	. Time of Death	
	Physicia		Virginia			Love				Month Mav	Day 6	2012		8:00 A M	
in a	Medic Examin		4a. Facility Name (if not institution, give s	street and number)			4b. Ci	ty, Town, or	Location of Death		4c. (				
ممددا			22321 Mt. Ephraim	Rd.				Die	ckerson	Mon			tgom	ery	
	Funeral		5. Social Security Number 6. Sec	x 7. Ag ☐ M 2 💢 F		ast birthday)	If Und Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da					
	Director		262-38-8403	- X	82	Yrs.					3.19	30 F	ountry) Lori	.da	
	nd <b>how</b> at	5	10a. State 10b. County		10c. Cit	y, Town or Lo	cation			_			10d.	Inside City Limits	
	laryla 3a-f s iffied	Director	MD Montgom	nery			]	Dicker	rson					1 XYes 2 □ No	
	or 28	ă	10e. Street and Number				10f. 2	Zip Code			10g. Citiz	zen of What C	ountry?		
	with 23a	era	22321 Mt. Ephraim	Rd.				208	842		Un	ited S	tate	s	
	eath tems er m	Funeral		1 ∐ Yes 2 X No If Yes, Give Year or Dates.			Vas Dec	edent of Hi	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	1	4. Race - Am		ndian,	
36	", or amin	by	1 Never Married 2 Married					2 No		o Alcan, etc.)		Black, Whi			
8	tural tural	ted	3 X Widowed 4 ☐ Divorced									Specify:	Whi	.te 	
5-	72 hc " na ledic	Completed	15. Decedent's Ed (Specify only highest grad				kind of v	vork done a	ation luring most of wor	king	16b. Kin	d of Business	s Industr	ry	
21215-0036	ithin ene. r thai	Con	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	Mana		ise retired)			Apai	rtment	Man	agement	
9	Hygi Othel	Be	17. Father's Name (First, Middle, Last)	-			-0		18. Mother's Nar	ne (First, Middle.					
<u>la</u>	토로 및 하 P Jack C. Love Mabel Tho									horpe			Drew		
Maryland	hould and N s ma		19a. Informant's Name/Relationship (Typ	pe, Print)		19b. Mailir	ng Addre	ess (Street a	and Number or Ru	ral Route Numbe	r, City or T	own, State, Z	ip Code	a)	
Σ	id 2 saith saith an 27 i		Sandra C. Breckenridge / Daug. 22321 Mt. Ephraim Rd., Dickerson, MD 20842										42		
Baltimore,	of He		20a. Method of Disposition  1  Burial 2  Cremation 3	Domestal from Ohaka		Place of Dispo			e)	Date	20c. Loc	. Location - City or Town, State			
Ĕ	Page ment ant: I		4 Donation 5 Other (Specify,				-		niv. 05/0	08/2012	]	Bethes	da,	MD	
alt	eparti eparti port vy inj		21. Signature of Funeral Service License	e M	00382	2 4	Name	and Addres	s of Facility d	Crematio	n Sei	rvices			
<u> </u>	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene.  Boolomian important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			nam					raf <sup>acility</sup> d Ave., Si			MD	209	010	
E			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on	ications that caused e cause on each line	d the deat e.	h. Do not ente	er the m	ode of dying	g, such as cardiac	or respiratory ar	rest,			proximate erval Between	
			Immediate Cause (Final disease or condition		On:	set and Death									
· Sand			resulting in death)	Due to (or as			1	020.							
		-E	Sequentially list conditions,	b. <del></del>	_	owel	010.	51406	non				1		
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ience of):									
	ecute and Il-tran	Еха	Cause (Disease or iinjury that initiated events c. resulting in death) Last Due to (or as a consequence of):												
0	De ei iciar ourià	ical													
	eath certificate b attending phys i for use as the l	ledi		0	-										
6876	certif nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1  Live Birth 2  Fetal death 3  Ectopic pregnancy						23d Da			of delivery		
Вох	eath e atte	icia	in the past 12 months? 1 \( \sum \) Yes 2 \( \sum \) No	4 Pregnant a				c pregnanc (specify)	у			Month	Day	Year	
). E	the d by the ache	hys	9 Unknown	9 Unknown											
P.O.	es that the dee signed by the a be detached t		Part II. Other significant conditions con	ntributing to death b	ut not res	ulting in the u	nderlyin	g cause giv	en in Part I.			A		use of death?	
ds,	/ requires been siç should b	Completed by								1 🗆	Yes 2	1 □ E OLA	Probably	y 4 🗌 Unknown	
202	aw reas be	ple								24a. Was		24b. Were a	utopsy f	indings available ation of cause of	
Re	The law cate has page 2 s	5									rmed?	death?			
ta	ilcian: The certificate rector, pag	Be (	25. Was case referred to medical examiner?			,		26. Pla	ace of Death (Ched	ck only one)					
<u>S</u>	Physic this o	유	1 Li Yes 2 /Li NO	lospital: 1  Inpati		ER/Outpatier	nt 3 🗆		4 ☐ Nursing H	ome 5 Thesic	dence 6	Other (Spe	cify)		
0	ding F h. After i funer	ate	27. Manner of Death  1 → Natural 5 □ Pending	28a. Date of inju (Month, Da		28b. Time of injury		28c. Injury work	?	28d. Describe h	now injury	occurred			
Division of Vital Records,	al or Attendin s after death. I Director: Aft d in by the fur	Certificate;	2 Accident Investigation 3 □ Suicide 6 □ Could not be	One Disease file	^^ !-	61-	M		Yes 2 No						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street and Number or Figure 28f. Location) (Street									Number or Ri	ural Rou	te Number,				
ONCO CONCORD TO STATE AND THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE															
	the Hospital or thin 24 hours afte the Funeral Dir mpleted filled in	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of e	xaminatio	n and/or invest	igation,	in my opinio	n, death occurred a	at the time, date a	and place, a	and due to the	cause(s	s) and manner stated.	
	To the within 2 To the comple	<	29b. Signature and title of certifier				-	9c. License				signed (Mon			
			> kun t	N871	MD		\	JA O	101039	5 33	02	1101	20 l	2	
			30. Name and address of person who co	mple ed cause of d	eath (Item	23a) (Type, F	rint)	• 0	11310	4-04-05	Δ / /	, Ω -	21	o. J. N/- 0	
)				bson	WI	LNIM	1	2091	DI WIS	CELIZIN	100	, 100	IVE.	THE PUT	
	Stat Registra	_	31. Date filed (Month, Day, Year)  JUN 1 1 20	2 32/Registra	ar's Signa	1. As	ute	1						sde MD 20889	

		. For	State of Maryland				_	_		
	_	State Registrar  1. Decedent's Name (First, Middle, Las	<i>+</i> 1	Cen	tificate of D	eath		Reg. No. 20	12	18361
Physicia Medic		PATTIE	MILLS				2. Date of Dea		2013	3. Time of Death
Examine		4a. Facility Name (if not institution, give	street and number)  AN HOSPITA	2	4b. City, Town, or BALT11		ARKAN	Ac. County	of Death	
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la.	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th	9. Birth Cour	nplace (State or Foreign ntry)
Director		Usual Residence of Decedent		5 Yrs.			06/06	11927		NC
with the Maryland s 23a or 28a-f show ust be notified at	Funeral Director	10a. State 10b. County		AUTI	ation MORE		•			10d. Inside City Limits  1 ▼Yes 2 □ No
vith the N 23a or 23 st be no	al Di	10e. Street and Number 3835 EIMORA		-	10f. Zip Code 216	1.12		10g. Citizen of V		intry?
€ 8 8	Fune	11. Marital Status	12. Was Decedent Ever in U.S.		as Decedent of His	spanic Origin? (Sp			e - Ameri	can Indian,
or	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕶 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		Yes, specify Cubar  ☐ Yes 2 No		o Rican, etc.)		k, White,	, etc. ACK
0 = 8	Completed	15. Decedent's Ed (Specify only highest gra	ducation	(Give k	ent's Usual Occupa ind of work done do		king	16b. Kind of Bi		
withii giene er th		Elementary/Secondary (0-12)	College (1-4 or 5+)	Me	NOT use retired)  ASS1	STANT		JEWIST	ERV	rices
e de f	To Be	17. Father's Name (First, Middle, Last) SAM WATSON				. 4	ne (First, Middle, Arri	Maiden Surname	)	
2 shou h and 7 is m traum		19a. Informant's Name/Relationship (Ty SHARON MIIIS	1	19b. Mailin	g Address (Street a	nd Number or Ru	ral Route Numbe	/		,
of Heall of Heall fitem 2 r other		20a. Method of Disposition	20b. PI		Sition (Name of atory or other place		Date	20c. Location -	City or T	Town, State
t. Page tment rtant: I		1 Surial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Ocens	MI	CALL	ARY	6/12	12012			e, Md er pr. 5cus
permit. Depart Import any inj			401553	4	905 Yor	K ROAC	· BAV	TO, MD	. 2	1212
Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		, ,			rest,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	a. ISCHEM  Due to (or as a conseque		AHOVION	1 XUPT / H	7		+	
	ner	Sequentially list conditions, if any, leading to immediate	b. ASCVD  Due to (or as a conseque	ence of):					$\dashv$	·
oe executed iician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):					$\dashv$	
be ey	ical	L								
certifical nding ph use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, outcome of <u>pr</u> egnan					23d Da	te of deliv	VAn/
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Other (specify)	4		Mo		Day Year
that the	by Ph	Part II. Other significant conditions co				en in Part I.	23e. Did to	obacco use contr	ibute to t	the cause of death?
requires been sig	eted	DIABETES MELLITO	)S, MIERIEN	08/0/0			1 🗆 '			obably 4 Unknown
law e 2	Completed						autop	osy ormed?	orior to co death?	ompletion of cause of
sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Othe	r:	ck only one)			
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate I completely filled in by the funeral director, pag	ate: To	27. Manner Death  1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ E 28a. Date of injury (Month, Day, Year)	R/Outpatient 28b. Time of injury	28c. Injury	4 ☐ Nursing H		dence 6 Other		<u>y)</u>
Attend er death ector: A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor			Yes 2 No		Street and Number	er or Rura	al Route Number,
spital or ours afte eral Dir filled in		29a. Certifier 1 Certifying Phys	building, etc. (Specify) ician: To the best of my knowle		Dourrad at the time	data and place	City or Tow		or oo etc	+ad
the Hos hin 24 h the Fun mpletely	Medical	(Check 2 ☐ Medical Examinonly one) 3 ☐ Certifying Nurs	ner: On the basis of examination e Practitioner: To the best of m	and/or investi	gation, in my opinior death occurred at the	n, death occurred a ne time, date and p	at the time, date a	ind place, and due	e to the ca	ause(s) and manner stated.
Voir Cor		29b. Signature and title of certifier  Acute The Land	welmon 1		29c. License			29d. Date signed		
K		30. Name and address of person who con HERBERT FRIEDMA 31. Date filed (Month, Day, Year)	ompleted cause of death (Item	23a) (Type, Pr	int)	/ U/ Q =	41 Ti Ma 2	or MAI	201.	W 21230
State		31. Date filed (Month, Day, Year)	62. Registrar's Signatu	ire	FAUEN BO	DV DK	WIIMOR	c 11/1/14	10151	VV 01007
Registra	r	JUN 1 1 2012	Sentra B.	gar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep		lental Hyg	iene	18362		
_		Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Deatl	eg. No. C U I C	3. Time of Death		
Physicia Medi		Catherine Ann Middlekauff		June -	7, Day 2012 Pear	6:55 A M		
Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	n		
Funeral		5505 Carter Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year I If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign		
Director	_	218-36-1428 1 \( \text{1} \) M 2 \( \overline{\text{x}} \) F \( \text{72} \) Yrs.	Months Days Hours Min.	(Month, Day, 01–26–1	Year) Cou	yland		
nd thow at	] ,	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	Baltimore	01-20-1	.940   Hat	10d. Inside City Limits		
Maryla 28a-f s otified	Director	Maryland N/A	Baltimore			1 ₺ Yes 2 □ No		
th the			10f. Zip Code 21214	1	0g. Citizen of What Co USA			
eath wi	Funeral	5505 Carter Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,			
36 after de l", or il	by	1 Never Married 2 X Married 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)		Black, White, etc.  Specify: White		
21215-0036 within 72 hours after giene. rer than "natural", o t, the Medical Exam	Completed	3 Widowed 4 Divorced Year or Dates.  15. Decedent's Education 16a. Dece	edent's Usual Occupation		16b. Kind of Business/			
215 lin 72 t le. han "r e Med	dwo	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	e kind of work done during most of worki DO NOT use retired)	ing		duony		
d 21 Hygier other t	Be C		emaker 18. Mother's Name	e (First Middle M	Own Home			
faryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at	일		Lucres	, ,	ights			
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)  Mr. David L. Middlekauff -Husband	ling Address (Street and Number or Rura 5505 Carter Avent		City or Town, State, Zip timore, MD			
re, rand 2 t Healt item 2 other i		20a. Method of Disposition 20b. Place of Disp	osition (Name of		20c. Location - City or			
imor Page 1 nent of ant: If it			Service Corp. 06-08	8-2012	Towson, Ma	ryland		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.			22. Name and Address of Facility Leonard J. Ruck, I	_	305 Harfordaltimore,			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	<del></del>			Approximate		
Physician/		shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition	died to finition			Interval Between Onset and Death Minute(		
Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	dial Infanction tic Cardiovavalar citus, type II			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	ner	Feguratially list conditions if any, leading to immediate Due to (or as a consequence of):	He Cardiovasular	Vilea	_			
executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c. <u>Diabeto Mell</u>	itus, type II					
		resulting in death) Last Due to (or as a consequence of).	•					
68760 certificate be rding physic use as the b	Medi	d						
x 68 th cert ttendin or use	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of del Month	ivery Day Year		
ords, P.O. Box 6876 requires that the death certificate been signed by the attending phe should be detached for use as the should be detached for use as the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the	Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		World	Day (ear		
Records, P.O. In the law requires that the ate has been signed by the page 2 should be detach	by P		underlying cause given in Part I.		acco use contribute to			
Records, The law requires ate has been sig	eted			1 TYe		obably 4 🗌 U <i>n</i> known		
Vital Reco sician: The law r certificate has E lirector, page 2 s	Completed			24a. Was ar autops perform 1  Yes 2	y prior to d	copsy findings available completion of cause of		
	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		2 № Nol 1 L Yes	2 No		
> Fr isin	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			nce 6 Other (Speci	ify)		
ing ing	cate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year) injury	of 28c. Injury at work?  M 1 □ Yes 2 □ No	28d. Describe hor	w injury occurred			
Division of pital or Attending Plus after death. eral Director: After the filled in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str City or Town,	reet and Number or Rur , State)	ral Route Number,		
			occurred at the time, date and place, a			ated		
Division  To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, deam only one)	stigation, in my opinion, death occurred at	t the time, date and	d place, and due to the o	ause(s) and manner stated.		
To t with To t		29b. Signature and title of cert lier	29c. License number		9d. Date sig <i>n</i> ed (Month			
		30. Name and address of person who completed cause of death (Item 23a) (Type,	D-17041		07 June	2012		
10		Marc I. Leavy M. 1734	York Road Lu	therville	m) 2	1093		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. August 32. Registrar's Signature 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33. August 33	Yorh Road Lu		/			
		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 Physician/ 3:59A Evelyn Mae Mudzo 8 June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll Hospice Dove House Carroll Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year, -30-192 105-24-5604 Director 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City. Town or Location 10d. Inside City Limits MD Carroll 1 ¥ Yes 2 ☐ No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Snowfall Way 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Was Deces.
Armed Forces?
Yes 2 X No 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Mayurnick Anna Chopyak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Logan - Daughter 303 Snowfall Way, Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) st. Nicholas 6-12-12 Taylor, PA 22. Name and Address of Facility Fletcher Funeral Home Main St., Westminster, MD 21157 254 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Brul Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♠ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🔲 No 1 🔲 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Lother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation ☐ Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of the Medical Examiner: On the basis of examination and/or investigation. whe time, date and place, and due to the cause(s) and manner as stated. (Check In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the bar 3 Certifying Nurse Practioner: ccurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 of death (Item 23

1

State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8364 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 Month Physician/ June 8 11:29 A<sup>M</sup> Fofo May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Months Hours 216-12-6940 Director 1 🗆 M 2 💢 F Virginia 89 Jan. 9, 1923 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 ☐ Yes 2 🎇 No MD Baltimore Lutherville 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Ä 23a Funeral item 27 is marked other than "natural", or items 23 other traumatic event, the Medical Examiner must USA 7 Candlelight Court 21093 filed within 72 hours after death al Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Medical Office Administrator Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last should be file and Mental F is marked o ည Theodore Paylos Aphrodite Zarocanelos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 7 Candlelight Court; Lutherville, MD 21093 Charlene Tomaselli / daughter 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o once. 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem. 6/12/2012 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or Approximate ause on each line Interval Between RID Fractile Onset and Death Immediate Cause (Final Physician weeks disease or condition resulting in death) Medical Due to (or as a consequence of) WED BY WEDLY ELAWINER **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) burial-transit CERTIFICATION Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 the SS IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) jo in the past 12% Month Day Year 4 Pregnant at time of death
9 Unknown signed by the at d be detached for 9 Unknown Part IL. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Inknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed death? certificate 2 🗌 No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work MAY 23 2012 UNKM 1 🗌 Yes Unwithered Investigation 6 Could not be filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 10821 YORK RD, COCKEYSVILLE MM) LIVING FACILITY ASSISTED Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

And Thanks MO 6701 N. Climbs ST Poursun M1 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\) For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month aymond Jure 1620 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Certer University of Maryland Medical Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 215-34-5332 74 Director 1 🛛 M 2 🗆 F 10/10/1937 Maryland with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Lutherville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral 1435 Bellona Avenue 21093 USA ural", or items a Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. by 1 Never Married 2 K Married 1 Yes 2 If Yes, Give Year or Dates. 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural" 3 Widowed 4 Divorced Specify: Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Towson Ford Sales College (1-4 or 5+) Mechanic <u>8th grade</u> Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ၉ Raymond Mosby Sr. Georgianna Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Florence Mosby/Wife 1435 Bellona Ave.Lutherville, Maryland 21093 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State  $06/1^{Date}/12$ Burial 2 Cremation 3 Removal from State Towson Maryland 4 Donation 5 Other (Specify) Pleasant Rest Cemetery 21. Signa y e o Funeral Service Licens 22. Name and Address of Facility Chatman-Harris Funeral 5240 Reisterstown Rd.Baltimore MD.21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician disease or condition Cancer Due to (or as a sequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami nding physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year signed by the at Id be detached for Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vinknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 after death.

Director: After this certificate 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 **V** No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 101802 June 6, 2012 person who completed cause of death (Item 23a) (Type, Print) Matthews

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

22

32. Registrar's Signature

South Greene St. Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04:30 AM **Physician** 30 GEKIKUDE 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/AJohns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | 1 2 / 0 4 / 1 9 2 9 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 213-28-6588 82 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show Director 1 XYes 2 ☐ No must be notified MD N/A 28a-f Baltimore 10f. Zip-Code 10e. Street and Number 10g, Citizen of What Country? 5 4906 Crenshaw Ave. Apt E 21206 23a U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black þ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) years Elementary/Secondary (0-12) Housewife N/A the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) r and Mental H Be William Burden Annie Jane Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 19a. Informant's Name/Relationship (Type. Print) Health em 27 Lillian Bradley(daughter) 1402 E. Baltimore St., Unit 100, Balto., MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory (10) (1) Baltimore, MD 21. Signature of Funeral Service Lisen Forephoder of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 acquera 23a and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he additional actions are actions. Approximate Interval Between Onset and Death Immediate Cause (Final HONTHS METASTATIC GASTRIC CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ Date of Injury (Month, Day Year) 27. Manner of Death Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation Injury 1 Yes 2 No

or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records,

I Director A To the Hospital within 24 hours a To the Funeral C

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES 000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANOREAS S.

4940 Eastern Avenue, Baltimore, MD, 21224

MAY 30, 2012

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 🗌 Suicide

JUN 1 1 2012

6 Could not be determined

140 2. Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1517 Physician/ MG 2012 Steven C. Marshall June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A ltimore University of Moryland Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Number 214-23-1026 Min Hours **Director** 1 XM 2 🗆 F Maryland 12/23/1971 40 or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State within 72 hours after death with the Maryland Director N/A Baltimore 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō must be r Funeral 21213 U.S.A. 1420 N. Bethel St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner n 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education City of Business Anduatrimore (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Court House Mental Hygiene. the 12th Grade Record Filing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Minnie unk Charlie Marshall Sr. . Page 1 and 2 should tment of Health and M tant; If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 N. Bethel St., Baltimore, MD 21213 Maxine Marshall(sister) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of h
Important; If ite King Mem Park 1 Burial 2 Cremation 3 Removal from State 06/14/12 Baltimore MD injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Josephadres of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, РА мБ21217 263 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician oyears disease or condition resulting in death) ischemic condionyopath Non-Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) idina physiciar Physician/Medical that the death certificate be Box 68760 as t JSe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No fo Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Inknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 🞾o To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗌 No 1 Doatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Aatural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in according to the cause of examiners and or investigation in according to the cause of examiners and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation in according to the cause of examination and or investigation and or invest Medical 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100484 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21201 22 South Greene 31. Date filed (Month, Day, Year)

JUN 1 1 2012 32. Registrar's agnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b,c,perfH,6928,6/11/2012,WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 Physician/ 7:55P Brenda L. Noll June 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 12/23/1942 215-42-2352 69 Director 1 M 2 X MD Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Carroll Westminster 1 Yes 2 No 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 1645 Rebnoll Trail 21158 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 0.10 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: White should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Norma L. Buckingham Irvin L. Constantine Sr. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Howard A. Noll-husband 1645 Rebnoll Trail, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hampstead South Carroll Crem 6-9-12 Winfield, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service 254 E. Main St., Westminster, MD 21157 homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cell static NOW-Small disease or condition Medical resulting in death) Due to lor as a consequence of) **Examiner** Sequentially list conditions Tany, leading to miniculate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the detached 1 Yes 2 g Unknown signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 Yes 2 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury Certificate: (Month, Day, Year) Natural 5 Pending M Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗷 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and K10102 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Stoner Westminster MD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year ONAM Physician/ Francis Elbert Old, III Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ranklin Square Hospita 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Baltimore, MD Nov. 15, 1943 215-44-1105 1 🛣 M 2 🗆 F **Director** 68 permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rijury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director Baltimore Parkville MD 1 Yes 2X No 10f. Zip Code 21 234 10e. Street and Numbe 10g. Citizen of What Country? 9301 Old Harford Road Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 M Married þ FRANCIS, ULU Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation Baltimore County (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Library Branch Manager/IT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Dorothy Miriam Moore ပ Francis Elbert Old, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9301 Old Harford Rd. Parkville, MD 21234 19a. Informant's Name/Relationship (Type, Print) Wendie Old- Wife 20a. Method of Disposition 20h Place of Disposition (Name of June 11, 20c. Location - City or Town, State Evants crenation (Name of Evants Crenation (Name of Evants Crenation of Chapel – Bel Air 1 Burial 2 X Cremation 3 Removal from State Forest Hill, 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Halt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Lung Can cer. disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law equires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has leen signed by the attending physician and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Vear Pregnant at time of death 2 No 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2 N 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury s after death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D72748 6/9/2012. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Che hab MD 9000 Franklin Square Drive Baltimore MD 21237

DHMH 17 Rev 06-2011

State Registrar

Mohamad 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ William Joseph Parker 2012 4:16 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, You Days Hours 215-30-7481 Director 1**XX**M 2 □ F 78 1933 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes XXNo Harford Maryland Jarrettsville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 4013 Security Lane 21084 United States or items within 72 hours after death Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Examiner þ 1 Never Married 2 X Married Specify:White 3altimore, Maryland 21215-0036 1 Yes XX No Specify: nan "natural", o Medical Exan If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Purchasing Agent the General Motors and Mental Hygie is marked other other traumatic event, Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Aloysius Parker Mary Gertrude Rennie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Parker / Wife 4013 Security Lane Jarrettsville, MD of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 12, Evans Funeral Chapel Bel Air Department of Important; If it any injury or o 1 
Burial 2 
Cremation 3 
Removal from State Forest Hill, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature / Funeral Service Licensee Evans Tuneral Chapel & Cremation Service-Belair 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Enysiciary** dusemineted encephalomyelitis weeks disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** (monon) brain Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician is the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 has page 2 After this certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPi 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death. Ineral Director: A Investigation filled in by the Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) d title of certifie 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N 6701 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:45A<sup>M</sup> 2012 June James S. Pleasant Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harbor Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1/23/29 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 126 M 2 □ F 83 Director 216-24-3753 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If item 27 is marked other then "neturn". 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Mansion Road 21090 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Specify: 3 ⊠Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Commercial Food Processor Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roscoe Pleasant 2 Mary Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Pleasant Son 35 Mansion Road Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory \* 4 □ Donation 5 □ Other (Specify) re Crematory 6/11/12 Baltimore Maryland
22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PS1 OSE Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Tank leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the the attending payed for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has blinector, page 2 s 1 Yes 2 No or Attending Physician: n 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filted in TN Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kam SM N. Kan mem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAPLE KACHINEN 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1.26 per doc g928 6-11-12 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Day Physician/ 2 Year М ALLE Raymond Palese mons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Holand Manor Assisted Living Towson 6. Sex 1 X M 2 □ F Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Aug. 14.1926 Hours Min. Maryland 212-20-0093 Director 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Baltimore Kingsville Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 11 Darney Court 21087 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian was becedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1944-1946 Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Oil Company Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alesander Palese Toskas Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ann Zukowski Daughter Darney Court Kingsville, Maryland 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 6-7-2012 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease. Approximate Interval Between shock, or heart failure. List only of Immediate Cause (Final Onset and Death Physician/ STACE disease or condition Medical resulting in death) Due to (or as a conjequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No for Pregnant at time of death
Unknown Month Day Year n signed by the a g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERJENSINN 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Assisted 1 ☐ Yes 2 📝 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Living Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation after death the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

12-04279 Domingo Quinones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2	0	Service Services	2		8	3	7	-
---	---	------------------	---	--	---	---	---	---

		1- For State Registrar	Certific	cate of Deat	h		R	eg. No		
Physici	an/	Decedent's Name (First, Middle, Last)				2	2. Date of Dea Month	Day	Year	3. Time of Death 1950 hrs
Medical Exami	ner	Domingo Quinones  4a. Facility Name (if not institution, give street and	number)	I dh. City 1	Town, or Locat	tion of Death	June 5, 2		c. County of D	
		Sinai Hospital	iumber)	Baltin		don or Death			c. County of Di	Saur
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) If Unde	er 1 Year If	Under 24Hrs.			I/DD/YYYY) 9.	Birthplace (State or
Director		551-38-7593 <sub>1×M 2</sub> -F	77	Yrs. Month	s Days H	lours Min.	08/0	4/1	934	reignPuerto Country Rico
		Usual Residence of Decedent								
w any		10a. State 10b. County	10c. City, Tow	n or Location imore						10d. Inside City Limits  1 X Yes 2 No
Maryland 28a-f show d at once,	草	Maryland  10e. Street and Number	Dait		0.1		1.	0. 0.	tizen of What (	
Mary or 28a	Director	5104 Levindale Road	1	10f. Zip 2 1 2				USZ		ountry?
with the Maryland ns 23a or 28a-f sho be notified at once,			ecedent Ever in U.S.	13. Was Decede		Origin 2 / Spe				merican Indian, Black,
eath w	Funeral	1 Never Married 2 X Married Armed	Forces?		fy Cuhan Mex	ican Puerto R	lican etc.)		White et	
fter de		1 X Yes 3 Widowed 4 Divorced If Yes, Give Y	2 No	1 X Yes 2	No spe	Puert	co Ric	an	Specify: Hi	spanic
ours a atura samir	d by	15. Decedent's Education (Specify only highest gr	ade completed) 16a	. Decedent's Usual during most of wor				16b.	Kind of Busine	ss/Industry
6 172 h	ete		(1-4 or 5+)	ssembly	-			G	eneral	Motors
within giene.	Completed	12th grade  17. Father's Name (First, Middle, Last)				other's Name (				1100015
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked uther than "natural", ar items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	BeC	Leopoldo Garcia				atasia				
212 212 Ment Ment mark	To B	19a. Informant's Name/Relationship (Type, Print )	1	9b. Mailing Address						tate, Zip Cooe)
MD 12 sho	Л	Ruth Quinones/wife		104 Lev						
Te, land land literal fiteral		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal		of Disposition (Nar atory or other place)	ne of cemetery	y, 06/	Date 13/12			or Town, State
Baltimore, ormit. Pages I and Department of Heal Impurtant: If item injury or other tra		4 Donation 5 Other Specify:	Garr	ison For	est V	et.Ce	meter	N N	ings .	Mills,MD.
alti mit. spartm parts jury o		21. Signature of Funeral Service Licensee		22. Name and	Address of Fa	acility Cha	tman-	Har	ris F	uneral Home
	0 0	Coller Hales		5240 F	Reiste	rstow	n Rd.	Bal	timor	e MD.21215
Physician III		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.					respiratory arr	est, sn	ock, or neart	Approximate Interval Between Onset and
Examiner			a consequence of):	tic Cardiovascu	ılar Diseas	e				Death
"		h	a consequence or).							
	펼		a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as	a consequence of);				<del></del>			<del></del>
uted nd ransit		dd.								
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED	)							
760, ficate be g physici the buri	Š		s, outcome of pregnanc	у				23	d. Date of deli	very
OX 68 eath certiff	ä	23b. Was decedent pregnant in the past 12 months?	birth gnant at time of death	2 Fetal death 5 Other (Spec		topic pregnan	су		Month	Day Year
Box 68 death certif the attending	Physician	4 D Vee o D Ve o D Helsense L H	nown	5 Other (Spec		<del></del>				
that the done of detached		Part II. Other significant conditions contributing	to death but not resulti	ing in the underlying	cause given i	in Part I.		_	_	to the cause of death?
ords, P.O. w requires that the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the	d by						1 Ye:	s 2	No 3 I	Probably 4 🗹 Unknown
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed						24a. Was autor	sy		autopsy findings available to completion of cause of
ecc The lav	E		-				1 Yes	rmed? 2 ✓ 1	deat	n? Yes 2 No
tal Reisian: The certificate	BeC	25. Was case referred to medical		:		eath (Check or				
Division of Vital Rec pital or Attending Physician: The I ours after death. teral Director: After this certificate I filled in by the funeral director, page	일	examiner?  1  Yes 2 No Hospital: 1	Inpatient 2 🗹 ER/0			4 Nursing			ence 6 0	ther:
Ing P		1 Mor	te of Injury 28b hth, Day, Year)	. Time of Injury	28c. Injury at V	_	28d. Describe	how in	jury occurred	
Sior Attend death ctor:	Certification:	2 Accident Investigation		(		2 No	Of Leasting /	Chanal	and Number of	Dural Bouta Number City
Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Division of Divisi	Ę	Suicide Could not be determined	ace of Injury - At home,	rami, street, ractory	, onice buildin	ig, etc.	or Town, S		and Number of	Rural Route Number, City
E Haspit c Haspit c Funcra e Funcra		29a. Certifier		eath occurred at the	time date an	d place, and d	lue to the caus	se(s) a	nd manner as	stated
Division of Vital Records, P.O. Box 68' To the Huspital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner:On the basi	s of examination and/or							
<b>1</b> × 1 × 5	Me	29b. Signature and title of certifier	oraleu.	290	c. License num	nber		29d.	Date signed (	Month, Day, Year)
2001		The day W Viel 7	RILLIN		O.C.M.E.	OCA	ΔE	Jur	ne 6, 2012	
2500		30. Name and address of person who completed ca								
			tant Medical Exar	miner 900 W.	Baltimore	Street, Ba	Itimore, MI	D 212	223	
S: Regis	tate	31. Date filed (Month Day Year) 32.	Registrar's Signature	KN						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Northwest Hospital Center Hospice Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Director 212-62-2749 1 🗆 M 2 🕱 F Oct. 1, 1958 53 Pennsylvania Usual Residence of Decedent show 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Carroll Maryland Hampstead 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4000 Gill Ave. 21074 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) sales order radio/Am. Red Cross 12 management assistant/ Be altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ano ...
of Health an.
\* item 27 is marn.
\* traumatic ev ပ Luvear Ernest Owens Sr. Nellie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong once. 4000 Gill Ave. Stephen A. Robinson/husband Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/11/2012 Pipe Creek Cemetery nr. Linwood. MD 22. Name and Address of Facility Hartzler Funeral Home, P.A. Signature of Funeral Service J atharine ( Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 03 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months' Month Pregnant at time of death Day Year Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 4 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Anatural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours a ithin 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title မ 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUK BOB a 40 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First. Middle, Last) 3. Time of Death 2. Date of Death Day 2012 Physician/ Month 9:30 p 4 Jane Ann Rich June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 618 Hammershire Road Owings Mills 9. Birthplace (State or Foreign Wester) Virginia If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🖔 F (Month, Day, Year) April 14, Months Days Hours Min. Director 233-34-2860 89 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 618 Hammershire Road USA should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housewife Own Home Be Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other frames. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Collins James Lewis Lenna Mav Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills, Maryland 21117 Roberta Bell Daughter 618 Hammershire Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 6/6/12 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road nen 21136 Reisterstown, MD ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ement disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death i signed by the at d be detached fo 1 ☐ Yes 2 ₺ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops\ performed Yes 2 page death? 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 🗆 Ko Other: 1 Yes ဂ္ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert G. Santmyer, Jr. June 5, 2012 7:09 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 409 Virginia Avenue Apt. 107 Towson 8. Date of Birth Feb. 16, 1943 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 69 215-42-1670 Director Maryland 1**XX**M 2 □ F Usual Residence of Decedent or 28a-f show notified at 0a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Towson Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or r must be r Funeral 21286 USA 409 Virginia Avenue Apt. 107 i "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. , or þ 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nt of Health and Mental Hygiene:
It if item 27 is marked other than
or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Department Store Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emily M. Erskine Robert G. Santmyer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health 93 Jumper's Circle Nottingham MD 21236 Julianna L. Cadden-sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important; If any injury or Parkwood Cemetery Baltimore Maryland 6/9/12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Road Inc. Baltimore MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phymician/ MYDCARDIAL ACUTE INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-tra the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D40480 Junt 6, 2012

Registrar
DHMH 17 Rev 06-2011

State

racke

7602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERRO, MD

Registrar's Signature

FERNANDO

JUN 1 1 2012

31. Date filed (Month, Day, Year)

on Lincoln Thornton, 111 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 5, 2012 Medical Examiner 0023 hrs LEON LINCOLN THORNTON III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 4415 Pall Mall Road If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Director Country 1\_yM 2\_F 6-15-1989 22 217-25-2155 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggene.
Important: If item 71 is marked ather than "natural", ar items 23s or 23s-f sho injury ar other fraumatic event, the Medical Examiner mast be aptified at once BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3952 OAKFORD AVE. 21215 USA Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SCHOOL -12--0-STUDENT 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be LEON L. THORNTON JR JACQUELLA P. CROSLINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JACQUELLA CROSLINE (MOTHER) 3952 OAKFORD AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Cremation 3 Removal from State 6-12-2012 METRO CREMATORY BALTIMORE, MARYLAND Other Specify uneral Service Licensee JONATHAN HIBN R. Name and Address of Facility HILLIPS FUNERAL HOME, P.A. 21. Signature of D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ure. List only one cause on each line Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or es a consequence of): events resulting in death) Last and transi Physician/Medical AMENDED UNPENDED led by the attending physician detached for use as the burial Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene DOA ER/Outpatient 3 this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred cation: Subject shot FOUND: Natural Pending 1 Yes 2 ✓ No 24 hours after death Funeral Director: filled in by the Jun 5, 2012 0057 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Certific 3 6 Could not be Suicide or Town, State) 4415 Pall Mall Road, Baltimore, MD (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa To the I vithin 2 2 [v] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3

State

Registra

31. Date filed (Month, Day

Carol H. Allan, MD

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

June 5, 2012

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical Month EDWARD UNDERWOOD W. 1024AM 06 JUNE 2012 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death GOOD SAMARITAN Baltimore HOSPITAL Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs. If Under 8. Date of Birth Birthplace (State or Foreign Country) Funeral 217-62-4983 (Month, Day, Director 1 **X**M 2 □ F 07 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Rosedale MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Kenwood 21237 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) POST OFFICE ostal Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Underwood 6003 Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/2012 Baltimore, Md Garrison 4 ☐ Donation 5 ☐ Other (Specify) GREENS FUNERAL SUS 21. Signature of Funeral Service Licenses M1436 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ Severe disease or condition Say Medical resulting in death) Examiner Bilaterm Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? w bilat 24a Was an plaural autopsy page 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

D0070632

6161

621 NEUTHW ST #306 Balhmon MD 21201

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDHAMMED

31. Date filed (Month, Day, Year)

JUN 1 1

KIDDUGAVU

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death O Month Physician/ 925 to Medical County of Death City, Town, or Location of Death Name (if not institution, give street and number) Examiner 11staur 8. Date of Birth . Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Month, Day, Months Hours Min. 1 M 2 Director City, Town or Location 10d. Inside City Limits 28a-f short 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Completed by Funeral Director 1 ¥Yes 2 ☐ No 4 more 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever if Armed Forces? 14. Race - American Indian 11. Marital Status the Medical Examiner Black, White, etc 1 Ner Married 2 Married 2 No ō 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: than "natural", 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) econday (0-12) College (1-4 or 5+) n and Mental Hygiene
7 is marked other the
fraumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surr 17. Father's Name (First, Middle, Last) ပ UnKnown Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition 1 Burial 2 Cremation 3 Removal from State 16-2012 4 more 4 Donation 5 Other (Specify) Kanda cations that caused the death. Do not enter the mode of dying, such as cardiac or 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ear Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Be Completed by Physician/Medical Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death g 🗌 Unknown Unknov Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown idney Disease - Stage 4 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has I autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital Rursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1) Natural work? 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 30. Name and address of person who completed cause of death ((tem 2) daystown MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Webster Physician/ June 9. 2012 5:00 P Elizabeth Julia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Examiner** Baltimore 3144 Woodring Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 4, 1922 Social Security Number 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 220-09-0593 90 Maryland Director 1 M 2 🕮 F Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy priant it item 27 is marked other than "natural", or items 25a or 28a-f sho amy priant in the 27 is marked other than "natural", and it is marked other than "natic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 3144 Woodring Avenue 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 x No Specify: Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Julia Self John Schneider 19a. Informant's Name/Relationship (Type, Print)
Townley T. Webster, III /son 19b. Mailing Address (Street and Number or Rural Foute Number, City or Journ, State, Zio Code) 3144 Woodring Avenue Baltimore MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗌 Burial 2 👿 Cremation 3 🗌 Removal from State Hilltop Service Corp 6/11/12 Towson Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Leonard J. Ruck, Inc. Signature of Funeral Service Licensee 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EREBNOVNAUM ACIPENT Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown Month Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed 1 Yes 1 Yes completely filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury Natural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 6 only one) 29b. Signature and title of certifier

- 01

31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

MTHERVILLE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40 21093 DR. DANIEL FEIRTAG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	- For Amend Items 23a pe	of Maryland / Liebs r dr.,g928,06/ Cer	TI/2012dhb tificate of Death	ı ivlental myç ı	gierie Reg. No. 🔿 🔘 📗 🤈	10292
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month 05	Day Year	3. Time of Death
1 4	Medic Examin	al	JOHN WIL SON  4a. Facility Name (if not institution, give street and nu	imber)	4b. City, Town, or Location of De		17 2012 4c. County of Deat	07:30PM
a may a se	LAGIIIII		MERCY MEDICAL CE	7. Age (In yrs. last birthday)	Baltimore, MD		Baltimo	re City
H	Funeral Director		5. Social Security Number 6. Sex  1 M 2 F  Usual Residence of Decedent	s. 8. Date of Birth (Month, Day 1 0 - 1 - 1 )	g. Birt Year) Cor	thplace (State or Foreign untry) MD		
	fand f show d at	tor	10a. State 10b. County			10d. Inside City Limits		
	e Mary r 28a-i notifie	Direc	MD  10e. Street and Number	Baltimor	10f. Zip Code		10g. Citizen of What Co	1 Yes 2 No
	th with th ns 23a o must be	Funeral Director	737 Yale Ave	Lus Luo Luo	21229		USA	
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show er tha Medical Examiner must be notified at	ρ	Armed F	Forces?	Was Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Pue I ☐ Yes 2 ☑ No Specify:	erto Rican, etc.)	14. Race - Ame Black, White Specify: Bla	e, etc.
15-0	72 hour	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give I	dent's Usual Occupation kind of work done during most of w	orking	16b. Kind of Business	
212	ed within 7 Hygiene. other than ent, the M		Elementary/Seconday (0-12) College	(1-4 or 5+)	O NOT use retired)  Service		Vending M	achine
pu	filed al Hy d oth	To Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, I	Maiden Surname)	
aryla	should be file h and Mental I 7 is marked o traumatic eve		John Riley  19a. Informant's Name/Relationship (Type, Print) Do		ng Address (Street and Number or I	ne Pratt	: City or Town. State. Zi	o Code)
X.	CV + CV		.Shareena Pratt	1559	Williams Ave, E			
Baltimore, Maryland	Page 1 and ment of Heal ant: If item 3 ury or other	•	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	III State	natory or other place)	Date  Km Diun	20c. Location - City or Dundalk	Town, State
Balt	permit. Page Department of Important: If any injury or once.	72	21. Signature of Funeral Service Licensee	22	Name and Address of Facility F 31 E. Oliver St,			rd FS
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	t caused the death. Do not ente each line.	er the mode of dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
	Medical			Spiratory Ac	rest			Onset and Beating
	Examiner	L	Sequentially list conditions, b.	Heart failur	e			
	pa sit	Examiner	If any leading to immediate Due to cause. Enter Underlying	docarditis				
_	cate be executed physician and the burial-transit	sal Exa	that initiated events C. ———	o (or as a consequence of):				
3760	ficate b g phys as the b	Medical	d		-	-		
Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed the hours and the death.  Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months?	egnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
ls, P.O.	w requires that the dea s been signed by the a should be detached to	þ	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I.		obacco use contribute to	o the cause of death?
of Vital Records,	The law req ate has bee page 2 sho	Completed						topsy findings available completion of cause of s 2 PNo
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1  Yes 2 No Hospital:		26. Place of Death (C	- 4		
n of V	iding Phys th. After this funeral di	cate: To	27. Manner of Death 28a. Dat	Inpatient 2  ER/Outpatier e of injury onth, Day, Year)			lence 6 Other (Spec ow injury occurred	ify)
Division	To the Hospital or Attending Physician: within 24 hours after dearfer. To the Funeral Director After this certific completed filled in by the funeral director.	Certificate:	3 Suicide 6 Could not be 28e. Place	ce of Injury - At home, farm, str ding, etc. (Specify)		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Examiner: On the b	asis of examination and/or inves	occured at the time, date and place tigation, in my opinion, death occurre death occurred at the time, date and	ed at the time, date a	nd place, and due to the	cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier  Young Zarll-	ID	29c. License number 139663  Print)  St., Roy	319	29d. Date signed (Mont.) May 17,	h, Day, Year)
			30. Name and address of person who completed ca Yousef Zarbalian, 2	use of death (Item 23a) (Type, F 2 2 South Gr	eene St. Ror	om 1/3 h	142 Baltin	21201 nore, MD
	Sta Registr		31. Date filed (Month, Pay, Ve 1) 2012 (22.	Registrar's Signature	Kel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc g929 7-6-12 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Susan Athas May 19, <sup>Day</sup> 012 6:56aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3514 Raymoor Road Kensington Montgomery If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Hours New York 1 /04 / 1 9 1 0 Director 1 🗆 M 2 ื F 102 il Hygiena. I other than "natural", or itams 23a or 28a-f show vent, the <u>Medical Examiner must be notified at</u> filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Kensington 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3514 Raymoor Road 20895 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home it. Page 1 and 2 should be filed wit rtment of Health and Mental Hygie rtant: If Item 27 is marked other? njury or other traumatic event, <u>th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Haralambros Theologus Argerio unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Kadala/daughter 3514 Raymoor Road Kensington, Md. 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven injury or 5/23/2012 Silver Spring, Md 4 Donation 5 Other (Specify) Signatur f Funeral Service Li PHNILE BRADER FOR P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Artenosclerotic Cardiovascular Disease Immediate Cause (Final Onset and Death Physician. Alzheimers Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami within 24 hours after death.

To the Funeral Director: Aftar this certificate has been signed by the attanding physician and complately filled in by the funeral director, page 2 should be detached for use as the burit-bransh Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 K No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify, 1 ☐ Yes 2 X No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat e Funeral Director: ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of cellifier 29d. Date signed (Month, Day, Year) D37142 May 21,2012 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) G.Cd eman MD 6001 Muncaster Mill Road Rockville, Md 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 24 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Month Physician/ J. Bailey 12:45 A M Bettv May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Citizens Care & Rehab Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Ohio 7. Age (In vrs. last birthday 8. Date of Birth
(Month, Day, Year)
Sept. 30,1925 **Funeral** 1 □ M 2 😾 F Hours 276-22-4708 86 Director Sept. Usual Residence of Decedent ral", or items 23a or 28a-f shorex Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 USA 7726 Kemp Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Jesse Fields ပ္ Edward McMeans 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7726 Kemp Lane Rd., Frederick, MD 21702 Donald Bailey, Sr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 5/22/2012 Frederick, Maryland 4 Donation 5 Other (Specify) Stauffer Crematory Stauffer Funeral Home Signatu of Funeral Service License 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that solved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on exchange. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of)

Ph\_si\_i\_n Medical Examiner

> burial-transit and

> attending physician for use as the buria

detached the

þ

Completed

Be

မ

Certificate:

Medical

signed by t

has

hours after death. Ineral Director: After this certificate

within 24 hours a

completed filled in by the funeral director,

To the Hospital or Attending Physician:

certificate be Box 68760

P.O.

Division of Vital Records,

show

Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a

Baltimore, Maryland 21215-0036

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death

23d. Date of delivery Month

4 ■ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

rred at the time, date and place, and due to the cause(s) and manner as stated

28d. Describe how injury occurred

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 No

Day

Year

25. Was case referred to medical examiner? 2 No 27. Manner of Death 1 Natural

Accident Suicide

4 Homicide

29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 5 Pending Investigation Could not be determined

SYED

28b. Time of 28c. Injury at 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de only one) 29b. Signature and title

26. Place of Death (Check only one)

and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mo

801 egistrar's Signature M. Billion

DHMH 17 Rev 7/2009

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Day Atha Marie Blades 12:10A M 2012 Medical May 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Caroline Nursing Home Caroline Denton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min. (Month, Day, Year) 1 M 2 3 213-14-8319 Director 90 28, Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Caroline Preston MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3297 Choptank Road 21655 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Poultry Grower 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hit: If item 27 is marked of y or other traumatic even Jacob Tilden Willey pe Ada Camilla Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Catherell Ct., Salisbury, MD 21804 Wayne Maurice Blades/Son Page 1 and 2 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) permit. Page Department o Important: If any injury or Junior Order Cemetery 05/30/12 Preston, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. Signature of Funeral Service Licensee Mishael 216 N. Main St., Federalsburg, MD 21632 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nysician/ disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or impury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year the 9 Unknown cate has been signed by page 2 should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Mursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ca 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

MAY 30 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\cap \) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY 2012 ROYAL BAILEY, SR. 11:05 p M L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Genesis Health Care Waldorf If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Hours Min. (Month, Day, Year b. 27, 1 Country) Director 226-60-1727 66 Feb. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Prince Georges Fort Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10850 Indian Head Highway #218 20744 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Armed Force 1 X Yes 2 No
If Yes, GiveVietnam
Era Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communication Operations Intelsat yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Garland L. Bailey, Sr. Lois Pretlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 10850 Indian Head Highway #218 Mildred Bailey - Wife Ft. Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bailey Family Cemetery 5-26-2012 Wakefield, VA 21. Signature of Funeral Service Licensee Marsharfdomarchilleruneral Home of Maryland Suitland, MD 20746 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause, Enter Underlying Cause (Disease or iinjury attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Month Day Year Pregnant at time of death Other (specify) ☐ Pregnant ☐ Unknown the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

Yo the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆

State Registrar

29b. Signature and title of certif

2070

OLD LINE CENTER WAYDEF, Mel 20601

cause of death (Item 23a) (Type, Print)

2-04072 Jobbie Lee Bro	wn	State of Maryland / Department of Health									
JODDIC LCC DIO		1- For State Certificate of Death		2012 18387							
Physici	_	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Dea	ath 3. Time of Death							
Medical Exam		Bobbie Lee Brown	Month May 29, 2	Day Year 1134 hrs 1134 hrs							
		, ,	n, or Location of Death	4c. County of Death							
		6228 Lee Place Capitol I		Prince George's							
Funeral Director			Days Hours Min.	irth(MM/DD/YYYY) 9. Birthplace (State or 1967 Foreign Washington, Country)							
		1 M 2 F 44 Yrs.  Usual Residence of Decedent	Novem	ber 29, Country D.C.							
any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits							
nd show	٦	District of Columbia Washington		1 X Yes 2 No							
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Co	de	10g. Citizen of What Country?							
hours after death with the Maryland instural", or items 23a or 28a-f she Examiner must be notified at once		19.19	0002	United States							
h with	Funeral	11. Marital Status 1 X Never Married 2 Married 2 Married 2 Armed Forces? 1 X Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent Co. 15. Married 15. Married 16. Married 17. Married 17. Married 17. Married 17. Married 17. Married 17. Married 18. Married 18. Married 18. Married 18. Married 19.  f Hispanic Origin? ( Specify Yes or N uban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.								
or deat	Fur	1 Yes 2 X No	No specify:	Specify: Black							
rs afte ural"	by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Doc	16b. Kind of Business/Industry								
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)									
036 ithin 'ine. r tha	Completed	7th grade Unemploy	None								
15-0036 filed within 72 Hygiene. ad uther than "t, the Medical."		17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,								
21215 ould be fill Mental H marked i	Be c	Phillip Dorsey  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (	Mary France	mber, City or Town, State, Zip Code 70745							
Shoul and N	P P	1.		xon Hill;Maryland							
imore, MD 21215-0036  Pages I and 2 should be filed wittin 72 hours after death with the Maryland men to Health and Mental Hygiene. Itant: If item 27 is marked uther than "natural", or items 23a or 28a-f sho ar other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of	f cemetery. Date	20c. Location - City or Town, State							
DOFC ages 1 nt of 1 nt: If i		1 Burial 2 X cremation 3 Removal from State 4 Donation 5 Other Specify:  Chesapeake Crem	June 11,20	Beltsville,Maryland							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Impurtant: If item 27 is marked inher than injury ar other traumatic event, the Medica		4 Donation 5 Other Specify: Chesapeake Cres 21. St. pature of Fun. V ervice Licensee 22 Name and Ad	ress of Facility R. N. Hort	on Company Morticians,							
Life ber De		Jangaph D. My MO1421 Inc.; 600	Kennedy Street, N	.W.;Washington,D.C.2001							
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of d failure. List only one cause on each line.	ring, such as cardiac or respiratory ar	rest, shock, or heart Approximate Interval Between Onset and							
//Medical Examiner		Immediate Cause (Final disease a. Morphine Intoxication		Death							
1		or condition resulting in death)  Due to (or as a consequence of):									
	er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
ted I Insit	Exa	events resulting in death) Last Due to (or as a consequence of):									
executed ian and ial - transit	ical	X UNPENDED AMENDED 23a, pt.II, 27, 28a-f, pe	er me,g928 6-22-1	2 sm							
760, ficate be g physici the burit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery							
Box 68760, s death certificate buthe attending physical for use as the buthe	an/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy	Month Day Year							
cath certific attending for use as the	sici	4 Pregnant at time of death 5 Other (Specify, 9 Unknown									
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I. 23e, Did	tobacco use contribute to the cause of death?							
P.O. es that the signed by be detact	Completed by	End Stage Renal Disease	1 Ye	es 2 No 3 Probably 4 VUnknown							
ords, F w requires to been sign should be	ete		24a. Was								
Reco The law cate has	Ē		perfe	ormed? death? 2 ✓ No 1 Yes 2 No							
tal Recians The certificate		25. Was case referred to medical 26.	Place of Death (Check only one)								
Vita nysicia this ce direct	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 Other: Scene							
of ing Ph After i uneral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c		how injury occurred							
ttendi death. the f	atio	2 Accident Investigation Id 3-29-12   Id 11:10am	Yes 2 X No unknow								
Division of Vital Records, pital or Attending Physician: The law require ours after death.  reral Director: After this certificate has been siftlled in by the funeral director, page 2 should b.	Certification:	3 Suicide 6 Could not be determined (Specify) Sound of the determined of the determined (Specify) Sound of the determined of the									
ospita hours nneral y fille											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)										
To To To Com	Med	and manner stated.	cense number	29d. Date signed (Month, Day, Year)							
	200		.C.M.E.	May 30, 2012							
		30. Name and address of person who completed cause of death (Item 23a)									
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. B	altimore Street, Baltimore, M	MD 21223							
	tate	31. Date filed (Month, Day Year) . 32. Registra's Signature									

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. C Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of 3. Time of Death Physician/ IRGE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 910 Somerset Place Hyattsville Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year 1957 579-78-6599 **Director** 55 January 9, Washington, D.C. Usual Residence of Decedent 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Prince Georges Hyattsville Maryland 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code č 10g. Citizen of What Country? Completed by Funeral 23a 20783 910 Somerset Place United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 X No If Yes, Give Black, White, etc. ò 1 Never Married 2 X Married Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) llth grade Master Auto Mechanic Koons Car Dealership Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 1 and 2 should be fired the and Mental fitem 27 is marked ဂ္ Edward Dennis Burge, Sr. Ann Elizabeth Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 910 Somerset Place; Hyattsville, Maryland 20783 Ruth Kay Cobb Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May<sup>D</sup>31, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify, 2012 Fort Lincoln Cemetery Brentwood, Maryland M01421 2Z. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Service Inc.;600 Kennedy Street,N.W.;Washington,D.C.20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Priset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific **Division of Vital** Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date igned (Month Day, Year) 31. Date filed (Month, Dav. Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G928 6/26/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 18389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Month May 24, 12:30 AM Frances Seabrook Bonafede Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase Montgomery Manor Care Social Security Numbe If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Hours Min Feb. 9, Year) 29 Florida Yrs. Director 266-36-5493 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8700 Jones Mill Road 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 🔀 Widowed 4 🗌 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lord & Taylor Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 J. D. Leslie Mamie Seabrooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McDonald, Conservator 13116 Ardnaes Avenue 20851 Rockville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 06/22/2012 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Tallahassee, Flordia Roselawn Cemetery Signature of Funeral Service Livensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John T. Stewer 20019 M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death dvona Physician/ 6125CN disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Yea ☐ Pregnant at time of death ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 tonknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 🗆 Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D005456 1241 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sunitable Blogavilli, 980/ (100 1910 April #1-17 5 Verspring INDC 902

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 0 1 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 19<sup>Day</sup> 2012<sup>Year</sup> MAY 9:31 P M BYRD GERALDINE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 7901 LAUREL LAKES COURT LAUREL Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 577-52-7217 1 M 2X F 72 WASHINGTON, DC JUNE 30 1939 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD PRINCE GEORGE'S LAUREL 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 20707 7901 LAUREL LAKES COURT 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 TNo Specify. Specify: BLACK 3X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) HOUSEKEEPER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ISABELL DIMES WILLIAM SHARPS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9225 ELVIS LANE LANHAM, MARYLAND 20706 BYRD/DGT. WANDA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Crema MD NATIONAL CEMETERY 5/29/2012 LAUREL, MARYLAND 4 Donation Other (Specia Signatur Funeral Service 22. Name and Address of Facility J, B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Part 1 Enter the disea shock, or heart failure Onset and Death MYOCARDIAL INFARCTION Due to (or as a consequence of) CORONARY ARTERY DISEASE YEARS Due to (or as a consequence of) HYPERTENSION YEARS Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify)

2 🗌 No

2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MAY

29d. Date signed (Month, Day, Year)

22,

Physician/ Medical Examiner

physician

attending

the

signed by

has

certificate

hours after death.

24 hours

executed

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

ms 23a or 28a-f show must be notified at

Examiner

Medical

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.

0.

"natural"

Director

Funeral

ð

Completed

Be

2

the Maryland

within 72 hours after death with

filed

Page 1 and 2 should be ment of Health and Ments

Maryland 21215-0036

Baltimore,

Examine burial-tran Physician/Medical the use as þ Completed page 2 funeral director, Be မှ Certificate: filled in by

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. E. ner Undenying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 X 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

pletely within 2

To the F

complet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Medical

4 Homicide

29a. Certifier

(Check

only one) 29b. Signatu

ANGÆLA DUNCAN, M.D.

and title of certifier

7350 VAN DUSEN ROAD #130, LAUREL, MARYLAND 20707

Date filed (Month, MAY 2 4 2012

determined

Registrar

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D43575

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		11	State of Maryland / [  State of Maryland / [  Registrar	Department of Health and N Certificate of Death	Mental Hygiene	12  839
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	OOKS	2. Date of Death Month Day MAY 18 2012	Year 3. Time of Death 4:40 A M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	of Death
	Funeral		1801 OREGON AVENUE  5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	HYATTSVILLE  nday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	E GEORGE S  9. Birthplace (State or Foreign
	Director		219-34-9775	Months Days Hours Min. Yrs.	JAN 30 1939	Country) MARYLAND
	yland f show ed at	iot	10a. State 10b. County 10c. City, Town		*	10d. Inside City Limits
	r 28a- notifie	Direc	MD PRINCE GEORGE'S HYATT	SVILLE  10f. Zip Code	10g. Citizen of W	1 Yes 2 □ No
	with the s 23a c ust be	Funeral Director	1801 OREGON AVENUE	20785	USA	mat Gounty :
030	e filed within 72 hours after death with the Maryland tral Hygiene. A first ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Married Forces.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:		- American Indian, k, White, etc. BLACK
9500-GLZ	nin 72 hours ne. than "natur e Medical I	Completed		Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)		
	filed with al Hygier d other I	oo ⊦	17. Father's Name (First, Middle, Last)	CARPENTER 18 Mother's Name	GOVERN e (First, Middle, Maiden Surname)	
U	ould be file of Mental marked of matic ever	卢	CHARLES BROOKS		E. WELLS	
Nar	sho han 7 is rrau	1	I I	Mailing Address (Street and Number or Rura 301 OREGON AVENUE HYA	•	
ore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.	-	20a. Method of Disposition 20b. Place of			City or Town, State
Daltimore	it. Pag rtment rtant: njury o	-	4 Donation 5 Other (Specify) RESURI			N,MARYLAND
D D	Depa Impo any i		21. Signature of Funeral Service Licensee  Daphney N. Cornelius	22. Name and Address of Facility J. 7474 LANDOVER ROAL		
٩	bysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		or respiratory arrest,	Approximate Interval Between Onset and Death
J. Same	Medical Examiner		Due to (or as a consequence of			
	sit a	niner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying	Q:		
	be executed sician and burial-transi	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t	f):		
	are be e ohysicia the bur		d			
D/90 X00	To the hospital or Attending Prysician: The law requires that the ceam certificate be executed within 24 hours after destin.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown  IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3	23d. Date Mon	e of delivery th Day Year
S, T.C.	uires tnat tne n signed by uld be detac	ģ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contril	bute to the cause of death?
Hecords,	rne law req ate has bee page 2 sho	Completed			autopsy pr performed? de	/ere autopsy findings available rior to completion of cause of eath? □ Yes 2 □ No
	cetor, ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	( only one)	
5 7	g rnys er this o	은 .	27. Manner of Death 28a. Date of injury 28b. T	tpatient 3 DOA 4 Nursing Ho ime of 28c. Injury at	me 5 🔀 Residence 6 🗌 Other 28d. Describe how injury occurred	
	renain leath. or: Aft the fur	Certificate:	2 Accident Investigation	njury work? M 1 □ Yes 2 □ No		
SINIC	al or An s after d Il Direct ed in by		4 Homicide determined 28e. Place of Injury - At home, fail building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,
-	nospira 24 hour Funera etely fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/o only one) 3 Certifying Nurse Practitioner: To the best of my know	investigation, in my opinion, death occurred at	the time, date and place, and due	to the cause(s) and manner stated.
1	vithin To the		only one) 3 Certifying Nurse Practitioner: To the best of my know 29b. Signature and title of certifier	29c. License number		(Month, Day, Year)
	R		AND-BC	Acooo 937	May 2	1,2012
	Ψ,		30. Name and address of person who completed cause of death (Item 23a) ( Melanic Pennolds ANP-BC	9200 Basil Ct.	5te 200	Lorgo MD ZoTT4
	Stat Registra	_	31. Date filed (Month, Day, Velar) 32. Registrar's Si frature			J
			4000			

Σ	d 2 sl alth a 1 27 is		EDITH BULL / SPO	DUSE	
Baltimore. M	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2XXCremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	MO MO	
09	Physician/ Medical Examiner  physician and the prival-transit	dical Examiner	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one cal Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d		- E
ords. P.O. Box 687	requires that the death certification is a second to the attending is should be detached for use as	To Be Completed by Physician/Medical Examiner	in the past 12 months?	If yes, outcome of prec 1 Live Birth 2 F F F F F F F F F F F F F F F F F F	C
Division of Vital Records. P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Compl	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	nital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At building, etc. (Sper	
Dį	To the Hospital or Attend within 24 hours after death To the Funeral Director; A completely filled in by the f	Medical C		n: To the best of my kno On the basis of examina	o
	Ut, in		30. Name of address of person who comp	THEN	,
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	ľ

		Pleas	se Type or P	rint in Bla	ck lı	ndelib	le Ink	. Ens	ure A	II Copie	s Ar	e Leg	jible.			
	For		State of I	Maryland /					and N	/lental Hy	gien	е				^
_	<ul><li>State Registrar</li></ul>				Cei	rtificat	e of L	eath			Reg. N	10.20	12	)	1839	2
1/	1. Decedent's Nam		Last) CHARD	BULL						2. Date of De		3 <sup>ay</sup> 20	o ¥1°2		Time of Death	M
al			give street and number			Ah Cihi	Terror Or	Location of	of Dooth	THOU					1:45A	/1
er			D DRIVE	,		1		PLA			4	lc. County CH I	ARLI			
	5. Social Security N	umber	6. Sex 7. /	Age (In yrs. last bir	thday)	If Unde		If Under		8. Date of Bir					(State or Foreig	n
	440-38-		1 🖾 M 2 🗆 F	72	Yrs.	Months	Days	Hours	Min.	apr. 1	1 , i	[940	OK.	ĽÄH	IOMA	
7	Usual Residence of 10a. State	10b. County		10c. City, Tow	n or Lo	cation	l							10d. I	Inside City Limit	s
ect	MD	CHAR	LES	WAL	DOR	F									1 🗌 Yes 2 🔀 N	10
	10e. Street and Nur	mber				10f. Zip	Code				10g. (	Citizen of \	What Co	untry?		
nera	2775 P	INEWOO	D DRIVE			2	060	1				U. S	s	Α.		
/Fu	11. Marital Status		12. Was Deceder Armed Forces	3?	13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe ı, Puerto	ecify Yes or No- Rican, etc.)			e - Ame		ndian,	
g Q	1 ☐ Never Marr 3 ☐ Widowed		ed 1 X Yes 2 If Yes, Give Year or Dates			1 🗌 Yes	2¥IXNo	Specify:				Specify.	WH	ITE	3	
lete	(Cno	15. Decedent				dent's Usu			4 - £ a l .		16b.	Kind of B	usiness/	'Industr	ry	
Be Completed by Funeral Director	Elementary/Seco		College (1-4 c	or 5+)	life. D	kind of wo	e retired)									
မ္က	17. Father's Name (	Einst Middle La	2	CR	IEF	MAS	TER	SER		N'I' e (First, Middle,		S.A		F O F	RCE	_
욘	JAMES V									RINE B			,	PKI	NS	
	19a. Informant's Na EDITH		p (Type, Print) SPOUSE	1g 2	b. Mailir 775	PIN	Street a EWO	nd Numbe OD D	R . , \	al Route Numbe NALDOR	er, City ( F , N	or Town, S IARY .	State, Zip LAN.	D 2	0601	
			3 ☐ Removal from Sta	20b. Place of cemeter METR(	ery, crer	natory or c	ther plac			Date 06/12		Location -				
	21. Signature of Fu		**	M0064	22	2. Name ar	nd Addres	s of Facilit	RAY	MOND F	UNI	. S	ERV	ICE	E, P.A.	_
			complications that caus										j	Apı	proximate	
	Immediate Cause (	(Final	nly one cause on each l	IN ICAS	N	101	(	un	Ja	٢					erval Between set and Death	
	resulting in death)	4	a. Due to (or as a consequence of):													
<u>~</u>	Sequentially list co	onditions,	b. —				)									_
Examiner	if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlying	Due to (or a	as a consequence	of):											
Exa	that initiated events resulting in death) I	S	c. Due to (or a	as a consequence	of):	<del></del>										
ca			d													
Med	IF FEMALE:															
ian/	23b. Was decedent in the past 12 i			h 2 🗌 Fetal deat				у				23d. Da	te of del onth	livery Day	Year	
Completed by Physician/Medical	1 Yes 2 Unknown		9 ☐ Unknow	t at time of death n	5 L	Other (s)	реслу)					IVIC	71111	Duy	rout	
<u>۲</u>	Part II. Other signif	ficant condition	ns contributing to death	but not resulting	in the u	ınderlying	cause giv	en in Part	l.	23e. Did t	obacco	use conti	ribute to	the ca	use of death?	
ed b										1 🗆	Yes	2 🗌 No	PI	robably	4 🗆 Unknow	/n
plet										24a. Was auto					indings available	
Sol										perfo	2 X		death? 1 □ Yes			
Be	25. Was case referre		Hospital:				26. Pla	ce of Dea								_
<u> </u>	1 Yes 2 2	No h	1 Inp	atient 2 ER/O	utpatier Time of		OA Cirie	4 ∐ Nu		me 5 Resi 28d. Describe I				ify)		_
cate	1 Natural 2 Accident	5 Pending	(Month, L		injury	M	work	? Yes 2 🗆		zed. Describe i	10W Inju	ary occurr	ea			
<b>Ħ</b>	3 ☐ Suicide 4 ☐ Homicide	6 Could n	ot be 28e. Place of I	njury - At home, fa	arm, str	eet, factor	y, office		$\neg$	28f. Location (			er or Rui	ral Rou	rte Number,	
<u>ğ</u>			building,	etc. (Specify)						City or Tov						
Medical Certificate: To	(Check 2	Medical Ex	Physician: To the best caminer: On the basis of	f examination and/	or inves	tigation, in	my opinio	n, death oc	ccurred at	the time, date	and plac	ce, and due	e to the o	cause(s		ıted.
Σ	only one) 3 29b. Signature and		Nurse Practitioner: to	tne best of my kno	wiedge		urred at the License		te and pla	ace, and due to		se(s) and n late signe				
_	1	ters	white	XIL	n	0	()	20	62	g		61	4.	1	2	
,	30. Name add	ess of person w	the completed cause of	f death (Item 23a)	(Type, F	(vigt)	12.	A	0	o Ros		M	Q -	21	0603	)
	31. Date filed (Monta			strar's Signature	ark	1	V			-	)	,				
r	JUN	11 1 201	L Come	P. 19	W	**						-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Delores Cahall 30 2012 7:20 p<sup>M</sup> May /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. Cily, Town, or Location of Death **Examiner** Hospice of Queen Anne's Centreville Queen Annes If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 79 Yrs. 8. Date of Birth (Month, Day, Year) 4-10-1933 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🕱 F 220-28-1922 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygione.
ant: If item 27 is marked other than "natural; or Items 23a or 28a-f show ury or other traumatic event, the Medical Examinar main be notified at 10b. County 1 Yes 2 No **Funeral Director** Centreville Queen Annes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3233 Price Station Road 21617 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Brooks Donovan Margaret Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Carolyn Garrett/daughter 13231 Oakland Rd., Ridgely, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)

Summit Cremation 6-1-2012 Wyoming, I Services, I.I.C

22. Name and Address of Facility Pippin Funeral Home, 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wyoming, DE 21. Signature of Funeral Service Licensee Inc. 149 W. Cam-Wyo Ave., Wyoming, DE 19934 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cervical cancer Metastatic 6 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner Due to for as a consequence of Hospital or Attanding Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the huria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZNo 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deat To the Funaral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature May 31, 2012 H0056873

State Registrar

DHMH 17 Rev 1/2001

30. Name and add

316 Railroad

31. Date filed (Month, Day, Year)

Goldshore MD 2/634

s of person who completed cause of death (Item 23a) (Type, Print)

32. R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maynth19. Cagle-Cheseldine 4:30 A M Darryelle Susan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 578-48-7147 74 **Director** 1 M 2 X F 08/09/1937 Washington, DC Usual Residence of Deceden or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Prince George's Oxon Hill 1 Yes 2XXNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7720 Oxon Hill Road 20745 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 **X M**No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2x No Specify: White "natural", Specify 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Secondary (0-12) Pharmacy Assistant Retail 12 years other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 12 should be file th and Mental h ပ David R. Dilda Bessie B. McKeithan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 James D. Cagle / Son 7720 Oxon Hill Road Oxon Hill, Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 Burial 2XXCremation 3 Removal from State Kalas Crematory 05/21/2012 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Sign of Funeral Service Licensee 22. Name and Address of Facili@eorge P. Kalas Funeral Home PA No 6160 Oxon Hill Rd. Oxon Hill, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the terval Between shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Silboo tall vilett secu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami tran and that initiated events resulting in death) Last physician a Physician/Medical requires that the death certificate be P.O. Box 68760 as 1 the attending IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 months? Month Day Pregnant at time of death 2 X No 9 Unknown Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1  $\square$  Yes ပ္ 1 Inpatient ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 No 1 Yes Accident Investigation pletely filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Mydical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Nurse ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature 29c. License number 29d. Date signed (Month. Day, Year) ompleted pause of death (Item 23a) (Type, Print) 30. Name and address

State

Registrar

egistrar's Signature

3 2012

		- State	e of Maryland / De	oartment of He e <i>rtificate of De</i>	ealth and M			12 183	95
	-	Registrar  1. Decedent's Name (First, Middle, Last)		- Lilicate of De	zati i	2. Date of Death	eg. No.	3, Time of Dea	ath
Physic Med		Margie Louise Dela				May	26 <sup>ay</sup> 20	)12 3:15 a	ı M
Exam	iner	4a. Facility Name (if not institution, give street and Mallard Bay Care Ce:	,	4b. City, Town, or Lo	ocation of Death		rchester		
Funera	al l	5. Social Security Number 6. Sex	7. Age (In yrs, last birthday	) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	·	9. Birthplace (State or Fo.	oreign
Directo	r	213-22-6171 1 ☐ M 2 🛣	F 87 Yrs.	Months	110010	June 29	, 1924	Maryland	
yland f show	tor	10a. State 10b. County MD Dorchester	10c. City, Town or I		1 . 1	-		10d. Inside City Li	
or 28a-	Dire	MD Dorchester  10e. Street and Number		10f. Zip Code	bridge	11	0g, Citizen of Wi	1 X Yes 2	□ No
s 23a o	Funeral Director	701 Race St. Apt. 21	6		.613	1	USA		
find 21215-0036 — () filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fur	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S. d Forces? Yes 2 X No , Give or Dates.	B. Was Decedent of Hisp If Yes, specify Cuban, 1 Yes 2X No	Mexican, Puerto	cify Yes or No- Rican, etc.)		- American Indian, White, etc. white	
15-C 72 hou n "natu Medical	nplet	15. Decedent's Education (Specify only highest grade comple	eted) (Giv	edent's Usual Occupation to kind of work done during DO NOT use retired)		ng	16b. Kind of Bus	iness/Industry	
Z1Z within giene. er tha		Elementary/Secondary (0-12) Colleg	ge (1-4 or 5+)	waitress			rest	aurant	
Maryland 2. 2 should be filed wit th and Mental Hygie 27 is marked other traumatic event, th	To Be	17. Father's Name (First, Middle, Last) Oscar Jenkins		1	8. Mother's Name	e (First, Middle, Mareighton	aiden Surname)		
		19a. Informant's Name/Relationship (Type, Print)   Karen Abbott da	I .	iling Address <i>(Street and</i> 5 Karen Cir					
<b>Baltimore</b> , cormit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal	from State cemetery, cr	position (Name of ematory or other place)	i			City or Town, State	
Baltimore permit. Page 1 a Department of H Important: If ite any injury or ot	5	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licepopee 1 €		y of Delmar 22. Name and Address			Delmar	·	
Dep Dep any		Veronica M. W.	elling	700 Locust	111	omas Fur mbridge,		ome P.A. 613	
Physician Medica	_	23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of immediate Cause (Final disease or condition resulting in death)	COROHARY A		such as cardiac o		t,	Approximate Interval Betweer Onset and Deatl	
Examine	r	Due	e to (or as a consequence of):	ADRTIC	STER	40-515			
ted I	Examiner	cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of).						
r bu ate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last	e to (or as a consequence of):						
ficate b g physicas the t	Aedical	d							
DIVISION OF VITAI RECORDS, F.O. BOX 08/00  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Me	in the past 12 months?	, outcome of pregnancy Live Birth 2 ☐ Fetal death 3 Pregnant at time of death 5 Unknown	Cother (specify)			23d. Date Mont	of delivery h Day Year	
es that the signed by	þ	Part II. Other significant conditions contributing PUL MONARY			in Part I.			ute to the cause of death	
ora: v requii	oletec		MONALE			24a. Was an	24b. We	ere autopsy findings availa	lable
VItal Kecords, ysician: The law requires is certificate has been sig	Completed	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	107W			autopsy perform 1 ☐ Yes 2	ied? de	or to completion of cause ath? □ Yes 2 □•No	a of
sician: certific lirector,	Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital:		Othori	e of Death (Check	, ,		<u> </u>	
OT V  ng Phys  ter this ineral d	ite: To	27. Manner of Dearn 28a. D	Inpatient 2 ER/Outpati	of 28c. Injury at		ne 5 Resider 8d. Describe how			
JIVISION OT al or Attending Pl s after death. I Director: After th ed in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	lace of Injury - At home, farm, s	M 1 ☐ Ye	es 2 🗆 No	204 Lanation (Ctus	and Alumbar	or Rural Route Number,	
UIVIS tal or A tral or A tral or A all Direct led in b		4 Homicide determined b	uilding, etc. (Specify)	treet, lactory, office		City or Town,		or nurar noute Number,	
the Hospi nin 24 hou the Funer. pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To to the Check only one) 2 Medical Examiner: On the Check only one only one of the Check only one of the Check only one of the Check only one of the Check only one of the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on th	basis of examination and/or inve	estigation, in my opinion,	death occurred at	the time, date and	place, and due to	the cause(s) and manner	r stated. :
No Pot		29b. Signature and title of certifier		29c. License no <b>D69</b>		29	d. Date signed (	Month, Day, Year)	
		30. Name and address of person who completed  JEEVAN EIRAS		<del></del>		AMBRIDGE	E MAKY	LAND 21613	3 .
St Regist	ate rar		2. Registrar's Signature	M	_ •	191.11000	1 1 71 1		- '
		THE PARTY NAMED IN	- A. A.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle | Last) 2. Date of Death 3. Time of Death Physician/ Ramirez Month 05 Judith Nieto De 2012 3:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park 7620 Maple Ave. 5. Social Security Number 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Min 1 M 2 X Hours 82 Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natural any once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USH 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 Calumbian 1 X Yes 2 ☐ No Specify: If Yes, Give 3 ₩Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) eau 1 110kvo~ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ UOKOOW N INKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avanue Takoma Park Maple 7620 easar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ignature of Funeral Service Licenses 22. Name and Address of Ficility Jenkins Ni 60 895 Reasundy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Arteriosclerosis Sequentially list conditions, Examine Due to for as a nonsequence of than, leading to himself cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Lymphoma B cell that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Day Pregnant at time of death 2 No Yes should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medica funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 I Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manyer as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Dr. Margarita E. Kullick, MD 1140 Varnum St. NE, Suite 203, Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 13853

May 23, 2012

20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rosemary Burke Dozier 20 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 285-34-0137 Director 1 M 2 X F 70 Usual Residence of Decedent Aug. 21, 1941 Ohio 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🛚 Yes 2 🗆 No Maryland | Prince George's Hyattsville 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 3103 Brightseat Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Specify: Black 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Secretary traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ permit, Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked Ralph Franklin Burke Sr. Mary Rose Pughley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 Bobby E. Dozier Sr. - Husband 3103 Brightseat Road Hyattsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If ite any injury 20c. Location - City or Town, State June 4, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 2012 Landover, Maryland 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Stewart Funeral Home, Inc. The all MA M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) avdicina DRath Medical Due to (or as a consequent of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Stage venal that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialsigned by the attending physiciar Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ☐ in the past 12 months?
1 ☐ Yes 2 🛣 No ō Month Day Vear 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 / No 1 Yes Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred

P.O. Box 68760

filed within 72 hours after

Baltimore, Maryland 21215-0036

requires that the death certificate be Division of Vital Records, the Hospital or Attending Physician: The law

within 24 hours after death.

Jo the Funeral Director: After this certificate has completely filled in by

State

Registrar

the

erry MA

5 Pending

Investigation

determined

6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

1/2 Natural

Accident

Suicide

29b. Signature and title

4 Homicide

29a. Certifier

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

21390

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5125112

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 20/3 1.30 PM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BLOOMINGVILLE GERMANIOWA MONTGOMERY 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral **Director** 1 M 2 🗆 F AKISTAN 1933 10 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No GERMANTOWN 10g. Citizen of What Country? Funeral 2040 BLOOMINGVILL USA 208 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. or i 1 Never Married 2 Married Completed by Yes 2 No Yes, Give within 72 hours after Maryland 21215-0036 1 Yes 2 No ASIAN "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) GOVERNMENT SERVICE AKISTAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ည NOOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🔾 6 57-1 19a. Informant's Name/Relationship (Type, Print) Health atem 27 ARKSBURG MO SOM 20b. Place of Disposition (Name of cemetery, crematory or other elementary) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 s Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens DODO # ON WAODBRIDGE 23a. Part 1. Enter the discase, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events use as the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 2 No filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes tructie Pulmona 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate ! Yes 2 No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. 1njury at work? 28d. Describe how injury occurred Certificate: 1 Natura 5 Pending 1 Yes 2 🗌 No Accident Investigation thin 24 hours after death the Funeral Director. 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely i (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signature and little 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/  $M_{av}^{Month}$  18. 2012 Alexander J. Eucare Sr. 9:57 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6708 Lansdale Street District Heights Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign Funeral 1 🖾 M 2 🗆 F Hours 85 08/31/1926 Maryland 579-28-9859 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No. Marvland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20747 6708 Lansdale Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Retir 1 Never Married 2 X Married \$ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Navy Commander Military 5+vears Juld be filk and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Valentin Eucare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 6614 The Parkway Alexandria, Virginia Alexander Eucare / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 KMBurial 2 Cremation 3 Removal from State Resurrection Cem. 05/23/2012 Clinton, Maryland 4 Donation 5 Other (Specify) of Funeral Service License 21. Signatur 22. Name and Address of Facilit George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ISHEMIC CARDIO MYDRATHY disease or condition Medical resulting in death) Examiner DISEASE 20 years CORONARY Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Yes 2 No ed by the a detached t 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC KIDNEY DISEASE 24a. Was an has autops, performed? DIABETES TYPE 2 Hospital or Attending Physician; The certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1XXYes 2 □ No Hospital: Other: ᅆ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No. 1 X Natural Accident Investigation within 24 hours after death

To the Funeral Director, of completed filled in by the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled in the incompleted filled filled in the incompleted filled  Suicide 4 Homicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

31. Date filed (Month,

DHMH 17 Rev 7/2009

Naveena Sompali, M.D., 1221 Mercantile Ln., Upper Marlboro, MD 20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/30/2012 George F. Farrell 6:56 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 577-40-3099 **Director** 1 X M 2 □ F 84 Maryland 01/29/1928 28a-f shov 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director Maryland Prince Georges Glenn Dale 1 Yes 2 No 10e. Street and Number 6 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 10124 Dolby Ave. USA 20769 items 2 Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Installer Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Farrell Elnora Farrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Farrell (Wife) 10124 Dolby Ave. Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or Chesapeake Crematory 06/01/2012 Beltsville, MD Signatur of Funeral Service Licensee Rendon/Hale Funeral Home 22. Name and Address of Facility 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 mset and Death Physician/ disease or condition resulting in death) METASTAN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on Exam burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No ed by the a detached 1 Yes 2 L 9 Unknown ate has been signed by t page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy репоrmed? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20110 ည 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Natural Accident iniury 5 Pending Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cerativing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 16

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ 19<sup>Day</sup> 2012 6:25p Clement Edward Gardiner III Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
July 6, 1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Maryland Yrs. **Director** 142-12-6104 91 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ħ the Maryland Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 7407 Willow Road 21702 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 K Married þ 1 ☐ Yes 2 K No Specify: If Yes Give Specify: Year or Dates. 1942-45 Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 4 Potomac Edison Director of Communications Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clement Edward Gardiner Jr. Margaret McPherson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12320 Auburn Road, Thurmont, Maryland, 21788 Christopher Gardiner/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Stauffer Crematory Inc.5/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland. 21. Signatur of Funeral Se Name and Address of Facility tauffer Family Services 201 North Market Street, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lumia resulting in death) Medical Due to (or as a consequence of): Zules. **Examiner** mo supsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): > 10 yrs CAD attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 KNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 2 2 🗌 No Yes 2 No 1 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) injury 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No M Investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wolf K100502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe, Kelly 10+1 21701 300 MA

DHMH 17 Rev 7/2009

State

Registrar

physical

32. R. gistrar's Signature

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2126 M Douglas Kenneth Gray 30 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Memorial Hospital EASTON TALboT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Director 1 XM 2 - F 78 Yrs Mar. 14, 1934 New Jersey other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Caroline Preston 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4606 Cedar Place 21655 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Jewelry Watchmaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Gray Ada Rose Flax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Gray/Spouse 4606 Cedar Place, Preston, MD 21655 Page 1 and 2 permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Eastern Sn. Veterans Cem. 06/05/12 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Tear 4ECTS Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transil Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year sate has been signed by the a page 2 should be detached 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No neart filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Hospital: ဍ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier De052255 hysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge, hesaleako DI. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2 Pay 20 Î 2 Nancy Mary Gearhart 7:15 Рм Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 401 Central Avenue Ridgely Caroline Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday 1 M 2X F Maryland 12/21/11953 Director 216-64-8633 58 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔃 Yes 2 🗆 No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 401 Central Avenue 21660 USA 12. Was Decedent Ever in U.S. Armed Forces?.
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Rentals Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Watson Satterfield, Sr. Mary Ida Rampmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank T. Gearhart/spouse 401 Central Avenue Ridgely, Maryland permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Donation 5 D Other (Specify) 6/1/2012 Ridgely, Maryland Ridgely Cemetery Signature of Funeral Service Li 22. Name and Address of Facility Moore Funeral Home, P.A. South 2nd Street Denton, Maryland 21629 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year the 9 Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\bigcirc$  Residence 6  $\square$  Other (Specify) 2 No မြ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending injury 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2.0.1.2

			For State Registrar	State of Marylan		artment of H tificate of D		vientai riy	Reg. No.	12 184	U 4
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last	Gaines		-		2. Date of De Month May 22		3. Time of De	eath Рм
	Medic Examin	al	4a. Facility Name (if not institution, give s			4b. City, Town, or I	Location of Death		4c. County of		PW
تحروب	Examin.	CI		tist Hospital		Takoma				ntgomery	
	Funeral		Social Security Number 6. Se.		ıst birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	Birthplace (State or F Country)	oreign
	Director			M 2 □ F 76	Yrs.	WOITING Days	Tiours Iviii.	Aug. 18		VA	
	ld now it	<u>.</u>	Usual Residence of Decedent  10a. State  10b. County	10c City	, Town or Lo	cation	1	rug. IC	, 1933	10d. Inside City I	Limits
	arylan a-f st	cto	,							1  Yes 2	
	or 28, notii	Ö	MD Mont	tgomery S	liver	Spring 10f. Zip Code			10g. Citizen of Wh		-
	with the	Funeral Director	10921 Inwood Aver	1116		20902	,		USA	,	
	eath v	-un-	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. \	Vas Decedent of His f Yes, specify Cuban		ecify Yes or No-	14. Race	- American Indian,	
036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a nor 28a-f show matic event, the Medical Examiner must be notified at	by	1 🏻 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		Yes 2 <sup>X</sup> No		HICAN, etc.)		, White, etc. White	
2-0	hour hatu dical	Completed	15. Decedent's Ed (Specify only highest grad			dent's Usual Occupa kind of work done du		rina	16b. Kind of Bus	iness/Industry	
2	nin 72 ne. <b>han</b> '	omi	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)	aning most or work	arig		1.	
2	ed with Hygier other t	Be C	0		Farm				Agricu	lture	
Maryland 21215-0036	12 should be file alth and Mental H 27 is marked or r traumatic evel	To E	17. Father's Name (First, Middle, Last) Eppie Gaines					e Tapp	Maiden Surname)		
ar)	should and h is ma		19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street ar	nd Number or Ru <b>r</b>	al Route Numbe	r, City or Town, Sta	nte, Zip Code)	
≥ `	nd 2 gealth m 27		Margaret Roey/Per	<del>-</del>		Bettswood	Drive, C	lney, MD			
Baltimore,	permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked any injury or other traumatic elone.		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	emetery, cren	sition (Name of natory or other place	May	Date 7 23, 2012		City or Town, State	
altin	mit. Pa bartme <b>bortan</b> r injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Juneral Service Licens.			tan Cremat Name and Address ancis		THE RESERVE TO SERVE	Alexandr		
m —	lm per		> Xohet	8 34	150	0 Univers	sity Blvo	1. W. S	Silver Sp		)901
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	fications that caused the death ie cause on each line.	n. Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Betwe	
	hydeian/	N I	Immediate Cause (Final disease or condition resulting in death)	a SEPTK	1HOC	K				Onset and Dea	atn
	Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	000	la Con	277			
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience ot):	10 ctccc	18 000	-(()		-	
	pe T	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	HYDGRCAS	MC	ROSINA	12 TORY	FAIC	URE		
	ian an	al Ex	resulting in death) Last	Due to or as a consequ			D	-1 al as	DKGAS	· Y	
09/	ate be	edical		d. C. HRWNIC	CRZI	RUCTIV	2 FUZM	PLATICA	CISCOT?		
89	ertific Iding   Ise as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d Date	of delivery	
Вох	eath c atter d for u	Physician/M	in the past 12 months?	1 Live Birth 2 Feta 4 Pregnant at time of d		Ectopic pregnancy Other (specify)	′		Mont	•	il.
B	the de by the achec	hys	9 Unknown	9 Unknown							
s, P.O.	law requires that the death certificate be executed has been signed by the attending physician and a 2 should be detached for use as the buriaterasis	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			oute to the cause of deal	
ord	been shoul	lete						24a. Was	an 24b. We	ere autopsy findings ava	ailable
Records,		Completed							rmed? de	ior to completion of cau eath? □ Yes 2 □ No	se of
<u> </u>	sician: The certificate irector, paç	Be C	25. Was case referred to medical	-		26. Pla	ce of Death (Chec	tk only one)	No 1	L Yes 2 L No	
Ž	ysicia is cer direc	To B	examiner? 1 ☐ Yes 2 🔼 No	lospital:	ER/Outpatier	nt 3 DOA Other	r: 4 🗆 Nursing H	ome 5 🗆 Resi	dence 6 🗆 Other	(Specify)	
0	ng Ph ter thi		27. Manner of Death  1. Natural 5  Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		at		now injury occurred		
on	eath. eath. or: Af the fu	fica	2 Accident Investigation 3 Suicide 6 Could not be			M 1 □ 1	∕es 2□No				
Division of Vital	I or Att after d Direct d in by	Certificate:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		28f. Location (S City or Tov		or Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification pletely filled in by the funeral director, completely filled in by the funeral director,	edical		ician: To the best of my knowl ner: On the basis of examination							er stated
	the I- hin 24 the F	Me	only one) 3 Certifying Nurs	e Practitioner: To the best of n		death occurred at th	e time, date and pl		the cause(s) and ma	inner as stated.	. stated.
	P C CO		29b. Signature and title of certifier	from mo		29c. License	number 957		29d. Date signed (		
	رت		20 Name and address of	1	22a) (Ti 5				MAT ZZ	12012	
			30. Name and address of person who co Randall P. Wagner,	, MD 20010	Centu	ry Blvd.,	Germanto	wn, MD	20874		
14	Sta Registra		31. Date filed (Month, Day, Year)  MAY 24 2012	32. Registrar's Signat	Lure Serv	D.					

18405 3. Time of Death 4:15  $P^{M}$ 

			Flea	State of			artment of			-		_	ibie.		
			for State Registrar	State of	iviaryiari		rtificate o		anu iv	lentai my	-	-2 U	12	18	340
			Decedent's Name (First, Middle	, Last)			- Incate of	Dodan		2. Date of De	Reg. No	).		3 Time	of Death
	Physici: Medi		LOUIS	GUPTON						Month MAY	2 <sup>D</sup> 2	y 2	012	4:1	
~ 1	Exami		4a. Facility Name (if not institution,	give street and numbe	r)		4b. City, Town	, or Location	of Death			. County			
-	4		BRADFORD OAKS C	ENTER			CLIN	TON			PR	INCE	GEO	RGE'S	
	Funeral		5. Social Security Number		Age (In yrs. la	ast birthday)	If Under 1 Ye Months Day		r 24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birthp	lace (State	e or Foreign
	Director		223-26-0670 Usual Residence of Decedent	1 🛛 M 2 🗆 F	90	Yrs.				APRIL		922			ROLINA
	ind show at	٦	10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside	City Limits
	Aaryka 8a-f s tified	rect	MARYLAND PRINC	E GEORGE'S	S	UITLAN	ID .							1 🕅 Y	′es 2 □ No
	the h	Funeral Director	10e. Street and Number			_	10f. Zip Cod	e			10g. Ci	tizen of V	Vhat Coun	itry?	
	with s 23a ust b	era	3791 MEADOWVIEW	DRIVE			207	46			UN	ITED	STA	TES	
	death item ner m	Fur	11. Marital Status	12. Was Decede Armed Force	s?	5. 13.	Was Decedent o	f Hispanic Or uban, Mexica	rigin? (Spe	cify Yes or No- Rican, etc.)	-		e - Americ k, White, e		
36	after I", or xamii	l by	1 Never Married 2 Marr	ied 1 X Yes 2 If Yes, Give Year or Dates	□ No		1 ☐ Yes 2 🛣			,		Specify:			
8	ours atura cal E	Completed	3 Widowed 4 X Divorced	Year or Dates	3,1743		dent's Usual Occ	cupation			1 401 1			ACK	
215	72 h an "n Medi	ldm	(Specify only highe	st grade completed)	F.)	(Give	kind of work dor O NOT use retire	ne during mos	st of workin	ng	16D. K	ina ot Bu	isiness/Ind	Justry	
212	withir giene er th	ပိ	Elementary/Secondary (0-12) 12TH	College (1-4	or 5+)	WEI	LDER				PRI	VATE	2		
Maryland 21215-0036	filed al Hy d oth	Be c	17. Father's Name (First, Middle, L	ast)				18. Moth	ner's Name	(First, Middle,	, Maiden	Surname	)		
yla	ld be Ment arke	2	JUDGE	GUPTON				CLA	NCY		BRAN	ICH			
Nar	shou and is m	00	19a. Informant's Name/Relationsh			L	ng Address (Stre							· · · · · · · · · · · · · · · · · · ·	,
6	and 2 lealth em 27 her tu		ELEANOR S. PEAC	E / NIECE			MEADOWV				_				6
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1		ate Ce	emetery, crei	osition (Name of matory or other p	olace)		)ate	l .		City or To		٨
Itir	iit. Pa urtmer ortant njury		4 Donation 5 Other (S		HAMI		EM GARD			5/2012				RGINI	
Ba	Depa Impo any i	9	21. Signature of Funeral Service L	censee	$\rightarrow$		2. Name and Add							-	
			23a. Part 1. Enter the disease, or shock, or heart failure, list o	complications that cau	sed the death line.	n. Do not ent	er the mode of d	ying, such as	cardiac o	r respiratory a	rrest,			Approxim Interval B	
part,	Ptrynician/	F 98	Immediate Cause (Final disease or condition	_ a ARTERI		OTIC F	HEART DI	SEASE						Onset and	
Q.	Medical Examiner		resulting in death)		as a consequ										
	_xamino	<u>.</u>	Sequentially list conditions,	b									_		
	sit sit	лiñ	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):							+		
0	be ex sician buria	call	,												
376	eath certificate k attending physi d for use as the l	ledi		a											
Box 6876	endin use	N/ne	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			☐ Ectopic pregna	ancv				23d. Dat	e of delive	ery	
Bo	death	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnar	nt at time of d		Other (specify)					Mor	nth	Day	Year
P.O. I	that the dea ned by the a e detached t	Physician/Medi	9 ☐ Unknown  Part II. Other significant conditio			data a ta ut a a	and at the constant	observato De A							
	es tha	by	Part II. Other significant condition	ns contributing to deat	ii but not rest	uning in the t	indenying cause	given in Fan	. 1.					e cause of	
rds	requires the been signer should be a	eted													Unknown
Division of Vital Records,	law has je 2	Completed								24a. Was auto perfe	psy ormed?	p	Vere autor rior to cor leath? Yes	mpletion of	s available f cause of
alF	ician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?				26.	Place of Dea	ath (Check		2 <b>X</b> N	4	res	Z 140	_
Vit.	Physician: This certificates and director, parall director, parall director, parall director, parall director, parall director, parall director, parall director, parall director, parall director, parallel  10 E	1 🗆 Yes 2 🔀 No	Hospital:	atient 2 🗌	ER/Outpatie	nt 3 🗆 DOA	Other: 4 🛛 N	lursing Hor	me 5 🗆 Resi	dence 6	Othe	r (Specify)			
of	fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of i (Month,	njury Day, Year)	28b. Time o injury	w w	jury at ork?	2	8d. Describe l					
ion	ttending P death. tor: After t	Certificate:	2 Accident Investig	ation		,	M 1	Yes 2							
ivis	p # F 드	Cer	4 Homicide determine	28e. Place of	Injury - At hor etc. (Specify)	me, rarm, str	eet, factory, offic	e	2	28f. Location ( City or Tov			r or Rural	Houte Nun	nber,
	ed is a	i = 1		- 1					- 1						

within 24 hours after death.

To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should b

To the Hospital or Attending Physician: The law require

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Prectitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

D 35206

29d. Date signed (Month, Day, Year) MAY 23, 2012

CAROLINA Inside City Limits 1 X Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701 LIVINGTON ROAD #101, FORT WASHINGTON, MARYLAND 20744 WILLIAM T. TANNER, M.D.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mae annie 2012 Medical 4a. Facility Name (if not institution, give street and number) Ac. County of Death
Prince Georges Examiner 4b. City, Town, or Location of Death Forestville Health and Rehabilitation District Heights If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 1 □ M 2 🔽 12-20-1920 South Cambina Usual Residence of Decedent show at 10c. City, Town or Location Director notified Prince 1 Yes 2 No 28a-f DISTRICE Heights 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r by Funeral Hil Mar Circle 2074 USA th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Black 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education School Teacher Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charlie Linasay Katie Bell WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a orraine Gar S Hil Mar Circle District Heights, MD 20747 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō Hay 31 2012 Arlington, Virginia Department Important: I any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raincy's Funcial Home Signature of Funeral Service Licensee Richmond, VA 23231 Williamsburg Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Arteriose Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury pue to for as a consequence of: the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month for ( Pregnant at time of death the 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rheumatoid Arthritis 2 No 3 Probably 4 Unknown 1 🗌 Yes Cerebral Infarction with 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? this certificate has 1 🗌 Yes completely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending 1 Natural work?
1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 D0026024 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, NE Washington, DC Varnum Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland (Departynant of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 28, <sup>D</sup>2012 Kevin John Gradoni 8:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5703 Mountain Laurel Place Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 3C. 28, 1990 214-31-9983 21 Director 1 M 2 D F Dec. ed other then "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at flied within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🕅 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5703 Mountain Laurel Place 21702 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc. Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Student Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be flie end Mentai F Is marked o ည Richard John Gradoni Kimberly Sines permit. Pege 1 end 2 should be Department of Health end Meni Important: If Item 27 Is marke any InJury or other traumetic v <u>once.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Gradoni / Mother 5703 Mountain Laurel Place, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 2th 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place Resthaven Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2012 Frederick, Maryland 21. Signature of Funeral Service Licensee Keeney and Basiord PA Funeral Home, Church Street, Frederick, MD Pen 1. Enter the disease / complications that caused shock, or heart failure. Let only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence off ettending physician and for use es the buriei-transit or Attending Physician: The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ No. been signal Completed 1 | Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical within 24 hou To the Fune completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) me and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signatu State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Ashley Henderson 7:55 PM 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Berlin Worcester Atlantic General Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Hours Month Pay Year) 5 2 Director 60 213-48-0733 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 31 Moonshell Dr. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed 3 Divorced 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Electrician County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H မ Warren Henderson Shirley Anne McGowan Lepatrment of Health and Important: If item 27 is many injury or other once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Debra L. Henderson 31 Moonshell Dr., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 5-29-12 First State Crem. Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burpage Funeral 108 William St., Berlin, HD 21811 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death the Unknown 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔏 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

DH 10 State

Registrar

ranklin

Ave. Berlin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lilah Gonzalez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alvin Seymour Hubbard 1810 MAY 3012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Easton Memorial Easton Talbot Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Country) Director 216-56-2001 59 1 🗶 M 2 🗆 F Feb. 5, 1953 Maryland 27 is marked other than "natura!", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 909 Central Avenue 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' e filed within 72 hours after datal Hygiene. ed other than "natural", or it Black, White, etc. 9 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 🛣 No Specify: white Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) tractor trailer repair trucking Be B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any Injury or other traumatic evel once. and Mental I ပ္ Alvin S. Hubbard Elsie McGlaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda M. Hubbard wife 909 Central Ave., Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 5/17/12 Delmar. DE 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): <sup>z</sup>Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retai Co...

Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N eral Director: After this certificate filled in by the funeral director, pag Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: 1 Yes Other: 잍 1 Phopatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funeral L Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifier ompleted cause of death (Item 23a) (Type, Print) 601 ald nth, Day, Year Registrar's Signature State Registrar

Alvin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hines Physician/ aul Month  $P^{M}$ 2012 5:40 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death and Reheb nursing DrestVille FORESTVILLE PRINCE GEORGE'S Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 XM 2 □ F FEB II. 78 NORTH CAROLINA T934 Director 245-42-3482 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Direct 1 X Yes 2 □ No PRINCE GEORGE'S CAPITAL HEIGHTS MARYLAND 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 623 CLOVIS AVENUE UNITED STATES 20743 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces or i Black, White, etc. Yes 2 XNo 1 Never Married 2 Married <u>۾</u> 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE PLUMBER filed wit al Hygien other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked or ပ ROBERT HINES ALBERTA NEWSOME 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 623 CLOVIS AVENUE, CAPITAL HEIGHTS, MARYLAND 20743 MILDRED HINES / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State HARMONY CEMETERY 05/26/2012 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. Naphnei 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final disease or condition Onset and Deat Pnysician/ Dements Advanced Medical resulting in death) Due to (or as a consequence of) Examiner 5troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last Hypertensem Due to (er as a consequence of): burialphysician s the burial Physician/Medical that the death certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate Yes 2 X No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury X Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide within 24 hours after death

To the Funeral Director: A

completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29d. Date signed (Month, Day, Year) 2012 21 D51520 2 PP pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co De 20032

Registrar DHMH 17 F by 7/2009

State

AHRAM

PISHOND, MO

304thern

1328

32. Registrar's Signature

Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHRISTINE MAY 2012  $P^{M}$ 6:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last hirthday) 8 Date of Right Davs (Month, Day, Year) Director 213-38-2111 1 □ M 2 🛛 F 85 1927 JAN. 23. MARYLAND Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 □ No MARYLAND PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8630 NORMAL SCHOOL ROAD UNITED STATES 20719 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. o þ 1 Never Married 2 X Married ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: BLACK "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) **5+** Elementary/Secondary (0-12) other traumatic event, the **EDUCATOR** GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H marked ဂ္ **JAMES** CHRISTINE ELIZABETH SIMMONS SR OUANDER and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra CHARLOTTE I CHASE / SISTER MARLBORO PIKE, UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND RESURRECTION CEMETERY 5/25/2012 21. Signature of Funeral Service License 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 Approximate Interval Pater Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 Month Day Year Yes P.O. þ nificant conditions contribuนักซี to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 1 Yes 3 🗌 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy perform 2 🗌 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes NNo Inpatient 2 □ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accider 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and m d (Month, Day, Year,

State Registrar Date filed (Month, Day, Year

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Jackson 5;15 Elizabeth May 22, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Somerset Pocomoke City 32285 Greenfield Court If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗶 F Director 220-16-9762 85 Maryland 08/21/1926 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Pocomoke City Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21851 8263 Bowlend Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Wholesale 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Elizabeth Martin Owen Melvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21851 32285 Greenfield Court, Pocomoke City, MD 21851 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other traus Stanley Jackson/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 K Cremation 3 D Removal from State 5/23/2012 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Puneral Service Licenses Funeral Home Professional Association Pocomoke City, Vine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to ( r as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No page 2 should be detached for ☐ Pregnant at time of death ☐ Unknown the g Unknown P.0. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy 2 No Yes 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Sath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title Wi Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<sup>Day</sup> Physician/ May Ralph Waldo Jackson 2012 4:30 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Hours May 15, 1922 217-36-0610 90 Mary land Director Yrs Usual Residence of Decedent or 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1945 Dailsville Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 X Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) farmer agriculture other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Waldo Jackson Marydel Taylor thent of Health and Mertault by the solution of Health and Mertaut: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Philip Jackson son 2206 Church Creek Road, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🙀 Burial 2 🗌 Cremation 3 🔲 Removal from State Department o Important: If any injury or once. Christ Churchyard 5/24/12 4 Donation 5 Other (Specify) Cambridge, MD 21. Si a of Funeral Service License 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cerebrovolcular Acute Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No be detached g Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 Yes 2 We Yes 2 No To the Hospital or Attending Physician: ompleted filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 340 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 C Hursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accider
3 Suicide Accident Investigation М 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 3-12-12 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMAN

DHMH 17 Rev 7/2009

State Registrar 503

Registrar's Signature

BYRN

SF

CAMBRIDGE MD 2613

TAMUR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>D</sup>2012 May 27 1:36 P M Gloria Jean Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Fort Washington 8011 Vernon Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F DC 225-54-3075 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ms 23a or 28a-f sho must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 No MD Prince George's Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8011 Vernon Drive 20744 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S the Medical Examiner Armed Forces Black White etc ò 2 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. 12 Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Dept. of the Navy Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, of Health and Mental H f item 27 is marked ot r other traumatic ever George P. Moody, Sr. Erma Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jan A. Desper - daughter 6409 Gwinnett Lane, Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State iffit 1 XBurial 2 Cremation 3 Removal from State Department Important: In any injury or 4 ☐ Donation 5 ☐ Other (Specify) Moody Family Cemetery 6/4/12 Bumpass, VA 21. Signature of Funeral Service Conse 22. Name and Address of Facility Genesis Cremation and Funeral Services udith 5732 Georgia Avenue, NV, Washington, DC 20011 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic breast Tyrs (2004) Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter oncenying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death in the past 12 months? Month Day Year for Pregnant at time of death ned by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by been signe should be Hypertension 1 Yes 2 No 3 Probably 4 Unknown Dyslipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner?
1 Yes 2 No Hospital: Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 6/1/2012 29b. Signature and title of certil 2 D37391

Registrar

State

Name and address of person who complete

Rochelle

31. Date filed (Month, Day, Year)

Hardy,

7404

Executive P1 #502 Lanham, MD 20706

ause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	f Maryla	and / Dep <i>Ce</i>	artmen <i>rtificate</i>			and M		giene Reg. No	201	2	18415
	Physicia Medic		1. Decedent's Name Eug	(First, Middle, ene	Last)  Dimit	ri	Krist	ofov	ich			2. Date of Dea May 1		2012 Year		3. Time of Death 2:45a M
0	Examin		4a. Facility Name (if Subur		give street and numb ospital	ber)				Location esda				Montg	ome	-
	Funeral Director		5. Social Security Nu 061-26-	1468	6. Sex 1 M 2 □ F	7. Age (In yrs <b>9</b> (	s. last birthday) O	If Under Months	1 Year Days	If Under Hours		8. Date of Birt 1 0 / 2 0 /		21 g. g	ountry UT	ce (State or Foreign Cey
	aryland a-f show fied at	ector	Usual Residence of 10a. State MD	10b. County	gomery	10c. (	City, Town or L	ncation hesd	a						10d	. Inside City Limits 1 ☐ Yes 2 🛣 No
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Num		ane			10f. Zip	Code 208	314			10g. C	itizen of What O	Country	?
936	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1  Never Marri 3  Widowed	ed 2 XMarrie	12. Was Deced	ces? 2 XNo	U.S. 13.	Was Deced If Yes, spec				cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wh Specify:		
N. Ger 215-0	hin 72 hours ne. than "natur ie Medical I	Completed	(Spe				(Give	edent's Usua kind of wo DO NOT use road	rk done d retired)	during mos	t of workin	g		Kind of Busines		America
and the	be filed wit ental Hygie ked other c event, th	To Be C	17. Father's Name (/		ne Krist	ofovi				18. Moth		(First, Middle,				
Mary	12 should alth and Me 27 is mar ir traumati		19a. Informant's Na Elizabe		p (Type, Print) Lensky/d	laught			1				_	or Town, State, andria		
Stof.	permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nı any injury or other traumatic event, the Medione.		20a. Method of Disp 1 🙀 Burial 2 4 🗌 Donation	Cremation	3  Removal from			creel	ther plac C CE	em. [	5/22	/2012	Wa	Location - City ashing	tor	n,D.C.
Kr. Salt	permit. Departr Import any inji		> /W	neral Service Li	/ Lucia	11	9	241 (	Colu	ımbia	a Bl	vd.Sil	ve	SERVI r Spri	CE, ng,	P.A. Md20910
	Physician/	17	23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or condition	rt failure. List or Final	complications that c nly one cause on ea	ch line.	eath. Do not er nonia	ter the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rest,		- ti	pproximate nterval Between Onset and Death
7	Medical Examiner		resulting in death)	a dialogo	Due to (		equence of): roderm	a								
•	uted Idea	Examiner	Sequentially list co if any, leading to in Cause (Disease or that initiated events	injury	С.		equence of):									
09	ate be executed onlysician and the burial-transit	edical Ex	resulting in death)		Due to (	or as a cons	equence of):							,	$\perp$	
Box 687	ath certific attending I for use as	by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 🗌 F nant at time	etal death 3	☐ Ectopic ☐ Other (s <sub>i</sub>		су				23d. Date of Month		r ay Year
s, P.O.	requires that the des been signed by the s should be detached	d by Pr	Part II. Other signif	icant condition	ns contributing to d	eath but not	resulting in the	underlying	cause gi	ven in Part	t I.					cause of death?
Division of Vital Records, P.O.	The law requate has been page 2 shou	Completed								-		24a. Was auto perfo 1 \sum Yes	psy	prior	to com	y findings available pletion of cause of
Tital	sician: The certificate irector, pag	Be	25. Was case referrexaminer?		Hospital:	Innationt 0	☐ ER/Outpati	ont 3 🗆 C	Oth	er.	ath (Check		donco	6 ☐ Other (Sg	necify)	
n of V	<b>iding Physician:</b> The la th. : After this certificate ha e funeral director, page	cate: To	27. Manner of Deat  1 X Natural 2 Accident		28a. Date (Mon		28b. Time		28c. Injur work	y at		28d. Describe		_	<i>Эеспу</i>	
Divisio	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director, After this completely filled in by the funeral di	Certificate:	3 Suicide 4 Homicide	6 Could r determi	not be 28e. Place	of Injury - A	t home, farm, s ecify)	treet, factor	y, office			28f. Location ( City or Tou		and Number or te)	Rural F	oute Number,
	he Hospit in 24 hour he Funera pletely fille	Medical	(Chook S	Medical F	Physician: To the b xaminer: On the bas Nurse Practitioner	sis of examina	ation and/or inve	estigation, in	my opini-	on, death	occurred at	the time, date	and place	ce, and due to t	he caus	e(s) and manner stated.
	within 12 Coor		29b. Signature and	title of certifier	ees	76	2	29		26259	9	_		ay 19,		
			30. Name and addr Ava Ka	ess of person v ufman	who completed caus	se of death (I	ite <i>m</i> 23a) (Type	in A	venu	ie Be	ethe	sda,Ma	ry	land		
	Sta Registr		31. Date filed (Mon			tegistrar's Sig	gnature	N.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:30 PM Albert M. Krout 6 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Health Services -Baltimore Dulanev Towson 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Days Hours Director 215-32-4035 1 🗶 M 2 🗆 F 79 5-12-1933 MD 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 West Road 21204 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 X Never Married 2 - Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) <u>General</u> Labor Nursery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည J. Paul Krout Margaret Francis Bull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobbie C. Seitler/Sister 1028 Freeland Rd., Freeland, MD 21053 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetry crematory 1 other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify 6-5-2012 <u>rect Service</u> York, PA 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. ature of Funeral Service Lice 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Cecum ('ancer Kec Physician/ and disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami that the death certificate be executed Cause (Disease or injury that initiated events and -train Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year 2 No g Unknown a Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signature and title of certifie H0054424 6-4-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Strus Asadı, 1012 Fallscraft way Luther Ville, MD 21093 32. Registrar Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 4:30 PM 2012 Physician/ MA HOWARD LANDIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE university of mary vand medial cente If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Min Months 187-30-2757 1 X M 2 D F April 19, 1930 Director Pennsylvania 82 Usual Residence of Deced 10c. City, Town or Location 28a-f show 10b. County and 2 should be filed within 72 hours after death with the Maryland ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Goldsboro Maryland Caroline 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21636 15346 Day Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11 Marital Status Black, White, etc. 1 X Never Married 2 Married þ 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) food industry Truck driver 80 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ehly Florence George W. Landis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2003 Busic Church Road; Marydel, Maryland 21649 Health a Donna K. Landis Smith/ niece other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Greensboro, Maryland June 1 2012 Greensboro Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility PO Box 160; Greensboro, Signature of Juneral Service Licenses Fleegle and Helfenbein Funéral Home, PÁ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TRAUMATIC BRAIN INJURY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) LAO 1 Examiner CENTIFICATION MARROTTO BY ME TAIL CHANNES FALL Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and after use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed' 1 ☐ Yes 2 ☐ No Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 Yes 2 □ No Be Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☑ No 5 Pending Natural
Accident FAUL FROM UADDER MAY 26,2012 LINK Investigation 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 15355 DAY RD GOLDSBORD HOWE Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funel

completely fi (Check only one 29d. Date signed (Month, Day, Year) 29b. Sigr ature ar 27,2012 1104088772 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201

DHMH 17 Rev 06-2011

State

Registrar

SOUTH

egistrar's Signatu

EUTAKI

71117

NADIA 31. Date filed (Month, Day, Year) GREENE ST BAUTMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year Clarita Month Marie Latortue May 20 2:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare-Layhill Center Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 072-82-5675 (Month, Day, Year) Director 1 M 2 X F April 26, 1925 Haiti item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, the Medical Examiner must be motified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Silver Spring 1 Yes 2XXNo Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3227 Bel Pre Road 20906 USA 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 X Never Married 2 Married δ 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify: Black If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within end Mentel Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Merian Latortue Aricie Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health end tem 27 is r Myrtha M. Cinada/Daughter 13110 Hathaway Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of Importent: If it eny injury or o ō 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) May 26 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2**0**12 Silver Spring, MD of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 00 University Blvd. W. Silver Spring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of): burjal-trapel Hospital or Attending Physician: The lew requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use es 1 ettending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No certificate has been signed by the irrector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 Yes 2X] No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and

State Registrar 3227 Bel Pre Road, Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Perpetual Guwani, CRNP

24

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

			Pleas	se Type or Pri							•		9	<b>).</b>		
		-	For State	State of M	larylan					nd Mer	ntal Hy	giene		^	101	1.0
			Registrar  1. Decedent's Name (First, Middle,	Last		Cer	titica	te of E	eath			Reg. N	0.20	4	184	19
	Physicia Medic	n/ al	Mildred	Helev	1	ew:	5				Date of De Month	ath 2	year 201		3. Time of De 00 · 36	
	Examin	er	4a. Facility Name (if not institution, of MEMORIAL		AL.		4b. Cit		Location of D	Death		40	C. County of Dea			
	Funeral		5. Social Security Number		ge (In yrs. la	ast birthday)	If Und	er 1 Year Days	If Under 24 Hours		Date of Bir (Month, Da			irthplac	e (State or F	oreign
	Director		Usual Residence of Decedent	1 🗆 M 2 🗗 F	9,	Yrs.				A	va.	al	000 11	ar	ular	20
1	show	for	10a. State 10b. County	4	10c. Cit	y, Town or Lo	cation				3/0	7	12 7 1	1	Inside City I	Limits
b	Maryland 28a-f sho otified at	irec	M) Talk	201		- 057	For	)							1 Ves 2	□ No
8	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or items 23a or 28a-f show with jointy or other treumetic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	ins Pla	ice.		10f. Z	ip Code 216	01			10g. C	itizen of What C	Country	?	
B	death items		11. Mantal Status	12. Was Decedent Armed Forces?			Vas Dec	edent of Hi	spanic Origin' n, Mexican, P	? (Specify	Yes or No-		14. Race - Am		Indian,	
36	after al", or xamil	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 Yes 2 12 If Yes, Give	No	- 1		/	Specify:		,		Black, Whi		L	
5-0036	72 hours after n "natural", or legical Examl	Completed	15. Decedent			16a. Deced					- 7	16b. J	Kind of Busines	a C		- 1
2121	nin 72 Je. Shen " e Mes	E I	(Specify only highes Elementary/Secondary (0-12)	College (1-4 or	5+)	life. D	O NOT u	se retired)	luring most of	working				,		
	ygier ther t	00 1	17. Father's Name (First, Middle, La	l		LYON	res	<u>+i`c</u>	Way				neone	e1:	5e'5 h	OME
Maryland	id be file Mental I larked o etic eve	2	Ma Shi !	-	0+1	<b>L</b>		ł	18. Mother's	Name (Fil	117	Maiden				
ary	should and M Is mar eumet		19a. Informant's Name/Relationship		<u>. U I I</u>	19b. Mailir	ng Addre	ss (Street a	and Number o	or Rural Ro			ر r Town, State, Z	Zip Cod	'e)	
	and 2 s Health a Gem 27 I		Theodore	Lewis	Jr.	612	E.	Dov		ree	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Sta	on M	D.	2160	)/
ore	ge 1 and it of H.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. F	Place of Dispo emetery, cren	sition (N	other plac		Date	1	20c. l	ocation - City c	or Town	, State	
Baltimore,	permit. Pege Department of Importent: If eny Injury or once,		4 Donation 5 Other (Sp		Sai	ndtow	NC			6/2	12	Hi	115601	co,	MD.	
Ba	Depar Impor eny In		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Home, P. A. Henry Funeral Home, P. A. Signature of Funeral Service Licensee												n. 21	613
			23a. Part 1. Enter the disease, or of shock, or heart failure. List on	complications that cau	the deat	h. Do not ente	er the mo					101 0	37	A	proximate	
z	Physician/		Immediate Cause (Final disease or condition		SEP	515								0	terval Betweenset and Dea	
4	, Medical Examiner		resulting in death)	Due to (or as		12-								<del>  '</del>	2112	
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):								⊢		
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events	с												
	e exection a cian a curial-d	न	resulting in death) Last	Due to (or as	a consequ	uence of):										
760	cete b physi s the t	edic		d				-								
Box 68760	eath certificete bu attending physic d for use as the b	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1						23d. Date of d	elivery		
Bô	death he atte	Sicis	in the past 12 months? 1  Yes 2  No 9  Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Other		у				Month	Da	y Yea	r
P.O.	hat the des ed by the s detached	Ę.	Part II. Other significant condition		but not res	ulting in the u	nderlvin	a cause giv	en in Part I.		23e Did to	obacco	use contribute t	to the c	ause of deat	th2
	S TOO	Completed by Physician/Medic								_			□ No 3 □			
200	law require has been si ge 2 should I	plet	2							1	24a. Was		24b. Were a	utopsy	findings ava	ilable
Re	Physician: The lar this certificate had ral director, page 2	Com									autor perfo	rmed?	death?			e oi
ta	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth.	ace of Death (	Check onl	y one)					- 11
) V	Phys r this eral dii	2	1 Yes 2 No	1 Nipat 28a. Date of inju		ER/Outpatier 28b. Time of		Othe 28c. Injury	4 LI Nursi				6 Other (Spery occurred	ecify)		
ou o	ath. r: Afte re fune	icate	1  Natural 5  Pending 2  Accident Investiga	(Month, Da	y, Year)	injury	М	work	? Yes 2 ☐ No	- 1	Describe r	iow inju	ry occurred			
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin				et, facto	ory, office		28f.	Location (S	Street ar	nd Number or R	ural Ro	ute Number,	
ā	Hospital of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the st	cal (	29a. Certifier 1 Certifying F	Physician: To the best of	f my knowl	ledge death	courred	at the time	date and pla	ace and d				ntatod		
	he Ho in 24 h he Fur pletely	Medical	(Check 2 L Medical Ex	caminer: On the basis of e	examination	n and/or invest	igation, i	n my opinio	n, death occur	rred at the	time, date a	and place	e, and due to the	e cause	s) and manne	er stated.
	To the within 2 To the comple		29b. Signature and title of certifier					c. License	number			29d. Da	ate signed (Mon	th, Day,		
	1						$\perp$	D00	0 66 6	+41		m	44 26	2	1012	
	V		30. Name and address of person w	ho completed cause of c AMESH	death (Item	23a) (Type, F S WA	rint) SH11	VKTO.	N STA	REET	E	AS	TON M	<b>^D</b>	216	01
	Sta		31. Date filed (Month, Day, Year)	22. Registr	ar's Signat	ture										
	Registra	ar .	MAY 3 0 20	112	. 1	200	No.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 Valearia May Lee 12:23p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge Chesapeake Woods Center Dorchester 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** June 16 Year 1925 1 M 2 🖈 Wyoming 218-16-9090 86 Yrs. Director Usual Residence of Decedent ral", or Items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must b 417 Atlantic Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: white 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Manford Nordwall Opal Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David D. Lee 417 Atlantic Avenue, Cambridge, MD son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Oregon Trail Vet. Cem. 1 X Burial 2 Cremation 3 X Removal from State Evansville, WY 5/31/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician/ disease or condition resulting in death) Medical Examiner anemiz Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed in page 2 should be det Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? is certificate h 1 ☐ Yes 2 ☐ No Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral o 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 No М Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Registrar

State

29a. Certifier

(Check

only one

29b. Signature and title of certifier

SINVUA 31. Date filed (Month, Day, Year)

MAY 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

H0059973

Dramble Combridge

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 577-26-1388 1 □ M 2 🗓 F 89 May 10, 1923 Washington, DC ust be notified at 10a, State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Davidsonville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21035 USA 728 Chickamauga Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force 6 1 ☐ Yes 2 🕅 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 ☐ Divorced "natural" Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Government Printing Elementary/Secondary (0-12) 12th College (1-4 or 5+) Ith end Mental Hygien 27 is marked other the traumatic event, the Librarian Office 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Ruth Clarkson William Nealon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Lieb Wilson/ Daughter 728 Chickamauga Dr., Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DE Veterans Cemetery 5/25/12 Millsboro, Delaware 21. Signature of Julieral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death CONGESTIVE HEART Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami OMPLETE or Attending Physician: The lew requires that the deeth certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last To Be Completed by Physician/Medical P.O. Box 68760 After this certificate has been signed by the attending p funeral director, page 2 should be detached for use es IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending after deeth. 1 Tes 2 🗌 No Investigation filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation in my coince. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of ce dayse of death (Item 23a) (Type, Print) ton 1 CHAEL 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G929 7/20/2012 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1248 Physician 30 - 2012 Shirley Lane Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial HOSPI Fastor Talloo . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 31 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year **216** 213-38-7575 Months Days Hours Min. 1 ☐ M 2 🗓 F 71 Director 1941 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Evandant and be notified at 1 ☐ Yes 2 No Director Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 4 Seward Road 21660 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Máryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 12 Loan officer banking industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester H. Lane ၉ Helen Marie Trice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Moore/ husband PO Box 52; Ridgely, Maryland 21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ridgely Cemetery June 4 2012 4 ☐ Donation 5 ☐ Other (Specify) Ridgely, Maryland 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 21. Signature of Juneral Service Licensee any Fleegle and Helfenbein Funeral Home, PA 11-Gu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) evere days **Physician** /Medical Due to (or as a consequence of): **Examiner** weeks nlo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 5 Other (specify) the 9 Unknown signed by the betach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\* Registrar

State

10.

31. Date filed (Month, Day, Year)

Myste

South

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Day William Daniel Miller ам 10 2012 8:13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9A Blue Bill Court Berlin Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Director 585-42-7430 1 M 2 □ F Oct. 19, 1949 NM 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland rel", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9A Blue Bill Court 21811 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 1 Ω Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White Year or Dates. 1967-69 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health end Mental Hygiene. em 27 is marked other thei ther treumatic event, the N Certified Master Mechanic Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ William Allen Miller Alice Joy Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Miller/Wife 9A Blue Bill Court, Berlin, MD 21811 Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o 1 A Burial 2 Cremation 3 Removal from State May 25, 2012 permit. Page Depertment of Importent: If any Injury or once. Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. Signatu 500 University Blvd. MD 20901 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Exsanguination due to Complications of Kidney Surger disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events Exam After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use es the burlel-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year 4 Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed To Be Certificate:

Division of Vital Records, P.O. Box 68760
Hospiter of Attending Physicien: The law requires that the death certificate be executed To the Hosofier of Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fun

Hypertension, Car	rdiovascular Dise	ease		1 □ Yes 2 □	No 3 ☐ Probably 4 ፟፟፟█ Unknown
				24a. Was an autopsy performed? 1 □ Yes 2基 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26	6. Place of Death (Check	only one)	
1 □XYes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient 3 DOA	Other: 4  Nursing Hon	ne 5 🖾 Residence 6	Other (Specify)
27. Manner of Death  1 Manner of Death  1 Pending  2 Accident Investigation	(Month, Day, Year)	injury v	njury at 2: work? I 🗌 Yes 2 🗆 No	8d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, offi	ice 2	8f. Location (Street and City or Town, State)	Number or Rural Route Number,
non Continue of Di Continue Division	nician. To the heat of my knowledge	dooth consend at the	time date and class on	d due to the source(s) as	d manage or stated

29b. Signature and title of certifier 30. Name and/a

(Check

only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

0028

2 201

ss of person who completed cause of death (Item 23a) (Type, Print)

J. Schweitzer, MD

29 S. Greene Street, Baltimore, MD 21201

State Registrar

Medical

5 +1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Leslie R. McCain, Jr Day Physician/ 2012 Year 20, 10:09a M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Month, Day Yea <sup>ar)</sup>1924 465-22-9265 13C3M 2 - F Months Days Hours 87 Yrs. Director Texas Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at rector Washington N/A DC 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 7820 20012 United States 12th Street, NW death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian ed Forces Black, White, etc. Ď 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates 2 No Baltimore, Maryland 21215-0036 72 hours after 1343 African 1 Yes 2 X No Specify: Completed 3 1 Widowed 4 Divorced A merican 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Juanita Bryant Leslie R. McCain, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
er 7820 12th Street, N.W., Washington D.C 20012 19a. Informant's Name/Relationship (Type, Print) Rosalyn L. Coates / granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Chesapeake Crematory 5/24/2012 1 Burial ZX Cremation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Furneral Service License 20012 7400 Georgia Avenue, NW, Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL INFARCTION ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DISEASE RON ARK TER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been HYPERT ENSIM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed the Hospital or Attending Physician: The law in 24 hours after death.

the Funeral Director: After this certificate has Empleted filled in by the funeral director, page 2 simpleded filled in by the funeral director, page 2 simpleded filled in by the funeral director, page 2 simpleded filled in by the funeral director, page 2 simpleded filled in by the funeral director, page 2 simplements. 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 No 1 Tes ျပ 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Watural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the I within 2 only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 200 PI D 40324 MAY 20, 2012 3+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK, MARYLAND JODRIE, MO, FACEP AVENUE. 7600 CARRELL TERM 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 24 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0812 William Frederick McGlaughlin 28 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester <u>1123 Ball Park Road</u> Fishing Creek 7. Age (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 1 X M 2 🗆 F Director 38-1462 Yrs 215\_38-1462 Usual Residence of Decedent 8-12-1940 MD or 28a-f shov 10a, State 10c. City. Town or Location items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Fishing Creek MD Dorchester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21634 1123 Ball Park Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, al Hygiene.

Jother than "natural", or iter vent, the Medical Examiner Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Shellfish Waterman 6 olth and Mental Hygie 27 is marked other r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Beatrice Creighton Willie Henry McGlaughlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau wife Priscilla McGlaughl Ball Rd. Fishing Creek. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dorchester Mem Pk:6-1-2012 Cambridge, MD Signature of Funeral Service Licenses 22. Name and Address of Facility 308 High St. Newcomb & Collins F.H. Cambridge,Md21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Speet and Death Immediate Cause (Final atherochotic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the Innerial Innerial innerial innerial innerial completely filled in by the Innerial Innerial completely filled by the State State Dural-Iransi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💭 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, ous 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

COM

00

Registrar's Signatur

ambrio

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jacob Alexar	nder	1	bley I- For State Registrar	State of Mary		epartment o Ce <i>rtificate o</i>		nd Men	tal Hyg		eg. No.	201	2	1842
Physician/ 1. Decedent's Name (First, Middle,Last)  Medical Examiner Jacob Alexander Mobley										Date of Dea Month	nth Day	Year	3. Time o	
INICUICAI LA			Jacob Alexano  4a. Facility Name (if not instit				4b. City, Town, o	or Location of		May 19, 2		nty of Dea		
		ı	2050 Elliotts Island	Road	,		Vienna				Dorch	•		
Fune		- 1	5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Ye	ear If Unde		B. Date of Bi	rth(MM/DD/YY			
Direct	or	L	221-76-4323	1 X M 2 F	23	Yr		lys Hours	Militi.	01/10,	/1989	C	ountry)	aware 
Á		-	Usual Residence of Deceden 10a. State 10b. Cour		10c. (	City, Town or Loca	tion						10d. Insi	de City Limits
br br	됈	_	Maryland Dorc	hester	t V	ienna								es 2 No
farylar	at on		10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Co	untry?	
3 or 2	ptified	5	106 Church S	Street			21869				USA			
cms 2	t be n	-	11. Marital Status  1 X Never Married 2		ecedent Ever in Forces?		as Decedent of H					ace - Ame	erican Indian	ı, Black,
A s :	L mus	[]		1 Yes	2 X N			o specify:		,,			White	<b>.</b>
urs aft	in :	٩	15. Decedent's Education (S	or Dates:		i) 16a. Deceder	nt's Usual Occup		kind of work	done	Specif 16b. Kind of			
6 72 ho	4	활	Elementary/Secondary (0-1	12) College	(1-4 or 5+)		ost of working lif	e. DO NOT	use retired)					
003( within jene.	Meli	Completed	12			Manag	er				Seafo		etail	Store
Baltimore, MD 21215-0036  Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho	ıt, the	- 1	17. Father's Name (First, Mid George Windoπ	•	Ir			ı		rst, Middle, I Lynn F	Maiden Surnai 1a11	ne)		
212 ould by I Ment	ic eve		19a. Informant's Name/Relation		J. •		g Address (Stre	eet and Num	ber or Rura	I Route Nur	nber, City or T		te, Zip Code	;)
MD id 2 sho lith and	amma (	٦.	Jeanne Johnson	n/Mother			Box 43	-						
ore, es l ar of Hea If itel	ber tr		20a. Method of Disposition 1 Burial 2 X Crema	ution 3 Removal		Ob. Place of Dispos crematory or ot				ate			or Town, Sta	
Baltimore, permit. Pages I an Department of Hee Important: If ite	y or 0		4 Donation 5 Other		C	rematory (			5/25/		De1mar			
Bal Permi Depar		1	21. Signature of Funeral Serv	Clcen	Nox		Name and Addres 211er Fu 06 Main	neral Street	Home	P. C	Box	207 <sub>v</sub>	m 216	31
Physicia		4	Part I. Enter the disease,	, or complications that	caused the de	ath. Do not enter t	he mode of dying	g, such as ca	ardiac or res	spiratory arr	est, shock, or	heart	Approxi	imate Interval
/Medic Examin	_		failure. List only one cau Immediate Cause (Final disea	0110	Sunshot Wo	ound of Head	Complicated	by Drowr	ning					en Onset and Death
	Ÿ.		or condition resulting in death	Dad to (or as	a consequenc	e of):								
		<u>ا</u> ق	Sequentially list conditions, if any, leading to immediate		a consequenc	e of):								
	٩.	티	cause. Enter Underlying Cau (Disease or injury that initiate	ed C.	a consequenc	e of):							1	
cuted	ransit	Ĭ	events resulting in death) La	d	2 331.03420113									
iO, e be executed ysician and	linal -	edical	UNPENDED	AMENDED										
3760 ficate	the bu	Z Me	F FEMALE: 3b. Was decedent pregnant i		, outcome of p		And divide 2	Cotonio			23d. Date		-	V
Box 6876 death certificate the attending phy	use as	Physician/M	past 12 months?	4 Preg	gnant at time of	( da = th	tal death 3 her (Specify)	Ectopic	pregnancy		Month		Day	Year
Bo ne deat	hed for	Š,	1 Yes 2 No 9	9 Unk							_l			
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy	detached f		Part II. Other significant con	iditions contributing	to death but no	ot resulting in the u	inderlying cause	given in Par	<b>1</b> I.		bacco use con			
ords, P.C w requires that as been signed b	onld be	<u>ğ</u>	-							24a. Was				ngs available
COF e law r	e 2 sh	Completed	-								rm <u>ed</u> ?	prior to death?	completion	
tal Recision: The	or, page 2		25. Was case referred to med	fical			26 Plac	e of Death (	Check only	1 Yes	2 No	1 🗸 Y	res 2	2 No
Vita ysicia his cer	§   C	නී   ' ර	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		Othor -			Residence 6	<b>✓</b> Othe	ar: Scene	
of Vi ing Physi After this	uneral	-12	27. Manner of Death	28a. Dat	e of Injury th, Day,Year) D:	28b. Time of I		ury at Work?	ان جا		now injury occu		drownod	-
Sion trendi death.	y the f			nvestigation May 19	9, 2012	FOUND: 1830 hrs		Yes 2	NO	Ject Silo	t sen in ne	and and	arowned	
Divis	ed in b	21	. $\Box$ de	odia not be	ice of Injury - A // Fishing I	t home, farm, stree	et, factory, office	building, etc	- 1	or Town, S	Street and Nun itate)			lumber, City
Hospit 4 hour Function			4 Homicide 29a. Certifier 1 Certifying	Physician: To the be			red at the time of	late and place			sland Road ,			-
DIVISIOI  To the Hospital or Attenwithin 24 hours after death	completely filled in by the funeral			Examiner: On the basis	of examination									
	<sup>3</sup>   :	2	29b. Signature and title of cert				29c. Licen:				29d. Date sig	gned (Mo	onth, Day, Ye	ear)
り							O.C.	.M.E.			May 20, 2	2012		
COME		[3	Name and a re- of pers Mary G. pipple MD.				W. Baltimore	e Street	Baltimor	e MD 21	223			
	Sta	te 3			Registrar's Sign		J. Baitimon		- aminon	C, IVID 21				
Reg	istr	аг	1. Date filed Way 2.4	ZUIZ ABIN	me h	T. Agreement								

2-03833 ary Ann Mills		Please Type or Print in Black Indelib State of Maryland / Departme				0 1010					
			te of Death		g. No.	2 1842					
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	1	3. Time of Death					
edical Exami	ner	Mary Ann Mills  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month May 19, 20	112 4c. County of Deat	1645 hrs					
		4026 17th Street	Chesapeake Beach		Calvert	•					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd			Forei	rthplace (State or					
Director			Yrs. Months Days Hours Min.	09/30/	1949 c	ountry) Wash.,D.C.					
Å.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits					
po A so	ŗ	Maryland Calvert Chesape	ake Beach			1 X Yes 2 No					
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?					
h the M 13a or Iotifie		4026 17th Street	20732		US						
ath wit fems 2	Funeral	1 Never Married 2 X Married Armed Forces?	<ol><li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li></ol>		14. Race - Amer White, etc.	ican Indian, Black,					
fter de:	Fu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: WI	nite					
ours a	od by	du	cedent's Usual Occupation (Give kind of wring most of working life. DO NOT use reti		16b. Kind of Business/	Industry					
36 in 72 h han "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ountant	Accounting							
d with giene	Com	17. Father's Name (First, Middle, Last)		8.Mother's Name (First, Middle, Maiden Surname)							
215 be file ntal Hy rked o	B	David Poole	Mary Poo	re							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	ပ		Mailing Address (Street and Number or F		,						
and 2 sealth a tem 27 traum		Michael Poole / Brother   314	Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Editorial Scalybark Drive, Edit	Blue Ridge, Virginia 24064  Date 20c. Location - City or Town, State							
ages 1 nt of H t: If it		1 X Burial 2 Cremation 3 Removal from State crematory	or other place) Memorial Gardens 5-24								
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		4 Donation 5 Other Specify: LARGIFORE 21. Signature of Funeral Serviced to endee	22. Name and Address of Facility Geo	orge P.	Kalas Funeral Home						
E E E E		/n// / h	2973 Solomons Islan	nd Rd.,	Edgewater,	MD 21037					
Physician Medical		236. Part Enter the disease, or complications that caused the death. Do not efailure. List only one cause on each line.		r respiratory arres	st, shock, or heart	Approximate Interva Between Onset and					
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Due to (or as a consequence of):	r Disease			Death					
		Sequentially list conditions, b									
	lner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Ciscopa or injury that injuries of the consequence)  C.									
od Sit	cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
executed an and al - transi	Sal	d. UNPENDED AMENDED									
60, ate be e hysicia	Medi	FFEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver						
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the burings.	Physician/Med	3b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Live birth 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna	ncy	Month [	Day Year					
Box death death death death death	ıysic	1 Yes 2 ✓ No 9 Unknown	Other (Specify)								
bat the	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to						
S, P puires t an sign	pe			1 Yes	2 No 3 Prot						
cord law red has bee	Completed	-		autops:	y prior to d	topsy findings available completion of cause of					
Rec : The fficate r, page		25. Was case referred to medical	26.Place of Death (Check of	1 Yes 2		es 2 No					
/ital	o Be	examiner?	Othor		tesidence 6 🗸 Other	: Scene					
Division of Vital Records, rai or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	-	27. Manner of Death 28a. Date of Injury 28b. Tim	ne of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred						
ttendi death.	atio	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No								
Divis al or A s after al Dire	Certification:	3 Suicide 6 Could not be determined (Specify)	, street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Ru ate)	ral Route Number, City					
Division of Vital   the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifin pletely filled in by the funeral director,		4 Homicide  29a. Certifier Continue Physician. To the best of my knowledge death	occurred at the time, date and place, and	due to the cause	(s) and manner as state						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only 2 Medical Examiner: In the Desir Infly knowledge, dearn one) 2 Medical Examiner: In the Desir of examination and/or investigation and manner stated.									
HRHR	M	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)					
			O.C.M.E.		May 20, 2012						
JAET	ſ	30. Name and address of person with completed eause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner	900 W. Baltimore Street, Baltim	nore, MD 212	223	<del> </del>					
H IU s	ate										
Regist	rar	31. Date filed (Month, Day, Year) NAY 2 3 2012 32. Fegistrar's Signature	pare								

DHMH 17 Rev 1/2001

	,			Pleas	se Type or Pr							_		gible.	
			For _ State		State of M	1arylar					ınd Ment	al Hyg	jiene	10	10120
			Registrar	(Fine 1414 )	(		Cer	tifica	te of D	Death			leg. No.	112	18420
	Physicia Media	_	1. Decedent's Name	e (First, Miadie, L	4. Mur	Ply					M	ate of Deat onth	Day	Year 2012	3. Time of Death  08/0 M
	Examir	er	\	1	ive street and number)	11	-/ 1		1	Location of	Death	_	4c. Coun	ty of Death	
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Funeral		5. Social Security N	umber 6	Adventis		ast birthday)	If Unde	er 1 Year	If Under 2	4 Hrs. 8 D	ate of Birth		nta	place (State Foreign
	Director		578-76-6		1 M 2 🗆 F	(07	Yrs.	Months	Days	Hours		onth, Day,		Cour	ntry) WEST
	land show dat	_	Usual Residence of 10a. State	of Decedent		10c Cit	y, Town or Loc	nation			10	7/16	1747	_	AICA, INDIES
	arylan a-f sh fied a	sct	MARYLAND	,	Georges		Be1tsv								10d. Inside City Limits  1   Yes 2 □ No
:	the M or 28 e noti	흅	10e. Street and Nun		0001800				p Code				10g. Citizen of	What Cou	1992
:	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by Funeral Director	4405 Pc	wder Mi	11 Road				20705	5			United	Stat	es
	death riterr iner n	Full	11. Marital Status	<b>V</b>	12. Was Decedent Armed Forces	?		Vas Dece Yes, spe	dent of His	spanic Origi n, Mexican,	in? (Specify Ye Puerto Rican,	es or No- etc.)		ce - Americ	
036	s after al", o Exam	q p	1 Never Marri		d 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes	2 <b>X</b> No	Specify:			Specif	70.1	ack
21215-0036	n 72 hours aft  an "natural", Medical Exa	lete	/Pno	15. Decedent's			16a. Deced	lent's Usu	ıal Occupa	ation			16b. Kind of I	Business/In	idustry
2	hin 72 ne. than ' te Me	mo.	Elementary/Seco		College (1-4 or	5+)					of working onment		_		nington
	<b>ゴ ユ</b> テ g	lost	17. Father's Name (f	First Middle Las	4 years		ASSIS	tant	Dire		Servic				Hospital
<u>an</u>	0 to 0	힏		Allen							trola		ntson	ne)	
Maryland	T and 2 should be file if Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Na			fe)	19b. Mailin	g Addres	s (Street a		or Rural Route			State, Zip	Code)
	2 ± 5 ±				White Mur	phy	4405	Pow	der M	1111 R	Road;Be	1tsví	ille,Ma	ry1ar	nd 20705
Baltimore,	ge 1 and it of Heal if item 2 or other		20a. Method of Disp 1 X Burial 2		Removal from State	20b. F	lace of Disposemetery, createry			e) <b>J</b>	une 2,	2012	20c. Location	- City or To	own, State
tin.	permit. Page 1 a Department of I Important: If ite any injury or ot			5 Other Cope	erify)	100	orge W			ı Ceme	etery		Ade1ph		
Ba	Deperment once		21. Signature of Fur	neral Service LV	KAM	14014									forticians, on,D.C.20011
			23a. Part 1. Enter the	ne disease, or co	omplications that cause	d the deat									Approximate
Р	hysician/		Immediate Cause (I disease or conditio	Final	y one cause on each lin	e. Mor	bai		01.	16					Interval Between Onset and Death
7	Medical Examiner		resulting in death)	4	Due to (or as		ience of):	C	ON	301					
	Examiner	70	Sequentially list cor	nditions,	, b. <u>Ga</u>	stri		anc	er						1.5 months
7	nsit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying	Due to (or as	a consequ	ience of):								
200	ician and burial-transit		that initiated events resulting in death) L	100	c. Due to (or as	a consequ	ience of):								
9	ysician re buria	ical			d										
Box 68760	ng ph	Mec	IF FEMALE:												
9 X G	ittendi for use	ian/	23b. Was decedent in the past 12 r	nonths?	23c. If yes, outcome 1 Live Birth	2 Feta	ideath 3 🗆			y				ate of delive	ery Day Year
. B	the a	ysic	1 Yes 2 Unknown	No	4 ☐ Pregnant : 9 ☐ Unknown		ieath 5∟	Other (s	pecity)		112		101	OHUI	Day Tear
Division of Vital Records, P.O. Box 68760	octificate has been signed by the attending physicator, page 2 should be detached for use as the b	Completed by Physician/Medic	Part II. Other signifi	cant conditions	contributing to death	but not res	ulting in the ur	nderlying	cause give	en in Part I.	23	3e. Did tob	acco use con	tribute to th	he cause of death?
ds,	en sign	pe.	Hype	rtens	ion	,						1 🗌 Ye	es 2 🗆 No	3 🗌 Pro	bably 4 Unknown
COL	as bee	plet	Hyp	erlipi	demia						2	4a. Was ar autops		Were auto	psy findings available impletion of cause of
Be E	ate ha	Con	Dia	bete 1	Mellitus						1	perform	ned2	death?	·
ital	Sertific rector,	Be	25. Was case referre examiner?		Hospital:				0.0		(Check only o	ne)			
J J	r this (	5: To	1 Yes 2 2 27. Manner of Death	No	1 Inpat		ER/Outpatient		OA Other	4 ∟ Nurs	sing Home 5				2
on c	ath. : Affel e fune	cate	1 ☐ Natural 2 ☐ Accident	5 Pending	(Month, Da		injury	м	work?	yes 2 □ N		escribe nov	w injury occur	rea	
Division of Vital Records,	after death.  Director: A I in by the f	ertif	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	t be	ury - At ho	me, farm, stre	et, factor	y, office					er or Rural	Route Number,
الم الم	urs aff ral Di	a C		/								ty or Town,	,		
H	within 24 hours after death.  To the Funeral Director. After this certificate ha completely filled in by the funeral director, page	Medical Certificate:	(Check 2	Medical Exa	hysician: To the best of miner: On the basis of e	examination	and/or investi	gation, in	my opinior	1, death occu	urred at the tim	e, date and	d place, and du	ue to the car	use(s) and manner stated.
ė,	vithin o the		only one) 3 29b. Signature and t		urse Practitioner: To the	ne best of m	ny knowledge,		urred at the		and place, and		cause(s) and 9d. Date signe		
	->-0		1634	> No la	mo M	D				662	74		75/21	hi	3 (7
			30. Name and addre	ss of person who	o completed cause of c	death (Item	23a) (Type, Pr		, , ,	U U L	-1	,	2010	100	
			Leeli	<u>e Se</u>	lassie		D Ca.	rol	14	venu	e Tal	coma	Park	Mc.	march 20912
	Stat Registra	_	SAY 2 5	2012 /	32. Registr	ar's Sichat	ure								9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nathaniel Augustine Miles 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hou*r*s 215-56-9629 1**XX**M 2 □ F 62 **Director** 06/11/1949 Wash.,D.C. show 10d. Inside City Limits 10c. City, Town or Location 10a. State the Maryland notified at Director Forestville P.G. 1 X Yes 2 No Md. 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or edical Examiner must be Funeral 20747 U.S.A. 1628 Tulip Avenue permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items
any injury or other traumatic event, the Medical Examiner mu
once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black White etc ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2XXNo 21215-0036 Black 1 ☐ Yes 2 ◯XNo Specify: 3 Ulidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education Prince George's (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Co. Government Courier vears Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Nathaniel A. Miles Thelma Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) Myra E. Miles/Wife 1628 Tulip Avenue, Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place, Harmony Mem. Park 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/05/12 Landover, Maryland 21. Signature of Funeral Service License Henry Mashington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. CC0316 arsi rall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of; the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural within 24 hours after death.

To the Funeral Director: After work? injury 5 Pending 2 🗆 No Investigation Accident 6 🗆 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D69796

State Registrar

DHMH 17 Rev 06-2011

HOSPITAL

DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jagdeet Singh, M.D.

31. Date filed (Month, Day, Year,

JUN 0 1 2012

≈03901	100		pe or Print in							egible	<b>)</b> .		
Ronald Eugene N		1- For State Registrar	tate of Maryla		ertificate o			Mentai H	, ,	Reg. No.	20	12	
Physicia Medical Examir	n/ ier	Decedent's Name (First, Middle Ronald Eugene     Facility Name (if not institution)	Magill	mber)		4b City To	own orlo	ocation of Death	2. Date of D Month May 22,	2012	Year		Time of Death 1008 hrs
			8660 Weddi		Ve	Welco		ocation of Death			harles	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under	_	If Under 24Hrs	_	Birth(MM/			lace (State or
Director		214-58-1694 Usual Residence of Decedent	1 M 2 F	60	Y	rs.	Dayo	Tiodis Will		2-19.	51	Count	Washington D.C.
any	ŀ	10a. State 10b. County		10c, Cit	ty, Town or Loc	ation		-				10	Od. Inside City Limits
Maryland 28s-f show d at once.	힏	Maryland Charl	les		Welc								Yes 2 No
or 28s	Director	10e. Street and Number 8660 Wedding D:	r.			10f. Zip (	<sup>Code</sup> 20693	3		10g. Citi:	zen of Wha	t Country	?
		11. Marital Status	12. Was Deco					anic Origin? ( Sp		No-	14. Race -		n Indian, Black,
er death , or ite	Funeral	1 Never Married 2 M	1 Yes	2X No	1			Mexican, Puerto	Rican, etc.)		White,		
urs afte		3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Year or Dates: cify only highest grad		16a. Decede		ccupation	n (Give kind of v			Specify: (ind of Busi	Whi iness/Indu	
5-0036 led within 72 hours after tygiene. I other than "natural", the Medical Taminar.	Completed	Elementary/Secondary (0-12)	College (1-	-4 or 5+)	1	most of work Farrie		O NOT use reti	red)	Th	oroug	hbro	d
15-003 lied withi Hygiene. d other th	چ	17. Father's Name (First, Middle,	Last)					.Mother's Name	(First, Middle			, HDIE	<u> </u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	James M. Magil	l, Jr.					Sara E.					
MD 2. d 2 should th and Me n 27 is m nmatic c	۱٩	19a. Informant's Name/Relations Jesse Magill/So						and Number or F					p Code)
and and fealt trans	ŀ	20a. Method of Disposition			. Place of Dispo	sition (Name		ne King	Date	20c. L	ocation - C	ity or Tov	wn, State
Pages lent of nnt: If		1 XXBurial 2 Cremation 4 Donation 5 Other Sp			een of		Cem.	. 5/31	/2012	Mec	hanic	svil	le, Md.
21. Signature of Funeral Service Licensee 22. Name and Address of FacilityArehart-Echols Funeral											ral	Home, PA	
Physician	MO0945 P.O. Box 56/ LaPlata, Md. 20646												Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	011-0	nshot Wou	ınd of Head							'	Between Onset and Death
	İ	or condition resulting in death)	Due to (or as a	consequence	of):								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	of):								
T ti	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):							_	
and	ਜ਼⊦	UNPENDED	d.	//a ner	mo c02	0 6 11	1.12	201		Æ - 0	20.00	/10/	2012111
Box 68760, e death certificate be ex the attending physician ed for use as the burial	Physician/Medic	IF FEMALE:	AMENDED #	utcome of pre		.0 0-1	1-12	Sm, 281	per l		. Date of de		2012dhb
K 687 s certifica ending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live bi		2 F	etal death		Ectopic pregna	ncy		Month	Day	Year
Box 68760, e death certificate b the attending physical for use as the burner.	nysic	1 Yes 2 No 9 Unk	known 9 Unknow		seath 5 C	ther (Specif	y)						
P.O. res that the signed by be detacned	S S	Part II. Other significant conditi	ons contributing to	death but not	resulting in the	underlying c	ause give	en in Part I.				_	cause of death?
ords, I w requires s been sign	eted				_	-	-		24a. Wa				sy findings available
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detacated for use as the buri	Completed								per	opsy formed? 2 No	dea	or to comp ath? Yes	oletion of cause of
Vital Rec	Be C	25. Was case referred to medical examiner?	Hospital:		7			Death (Check of					
n of Vit ding Physic After this funeral dire	와	1 ✓ Yes 2 No 27. Manner of Death	28a Date o	patient 2 of Injury	ER/Outpatier 28b. Time of		c. Injury a		Home 5				ene
tending eath.	ation	1 Natural 5 Pend 2 Accident Inves	FOUND: May 22, 2		FOUND: 0930 hrs		1 Yes	2 🗸 No	Subject sh	ot self			
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: Completely filled in by the t	Certification:	3 Suicide 6 Could deter	d not be 28e. Place		home, farm, stre mily Home	et, factory, o	ffice build	ding, etc.	28f. Location or Town	(Street ar State)	Id Number	or Rural F	Route Number, City ing Drive 20693
Hospit 24 hour Funers reely fill		4 Homicide  29a. Certifier 1 Certifying Pr	nysician: To the best	of my knowle	dge, death occu	ırred at the ti	me, date	and place, and	due to the ca	use(s) and	d manner as	s stated.	
To the within To the comple	훓ᆫ	one) 2 Medical Exam	miner: On the basis of and manner sta	f examination	and/or investiga	ation, in my o	pinion, de	eath occurred at	the time, dat	e and plac	ce, and due	to the ca	
	2	29b. Signature and title of certifie					License n				ate signed 23, 2012		Day, Year)
10 m	-	30. Name and address of person	who completed cause	e of death (Iter	m 23a)								
			nt Medical Exam			re Street,	Baltim	ore, MD 212	223				
Sta Registr		JUN 1 2012	Several 32. Reg	gistra s Signa	ave								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Marylar	•	artment rtificate			and M		giene	012	2	181	+31
	Physici		Decedent's Name (F	irst, Middle, Las Aud		e Mart	in					2. Date of Dea Month May	Day	20		3. Time of 2:32	
	/Medic Examir		4a. Facility Name (If no.	t institution, give	street and nu	ımber)		4b. City, 1	Town, or	Location of	of Death			County of D			
1	_ Admi		Coffman	Nursing	Home			Haş	gers	town				Wash:	ingt	on	
	Funeral Director		5. Social Security Numb 215-26-165		ex □M 2⊠F	7. Age (In yrs.	last birthday) 3 Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day Feb. 17	Year) 1929	9.	Birthpl Coun Vi	ace (State try) rgini	or Foreign a
	pu »		Usual Residence of De	cedent b. County		10c Ci	ty, Town or Lo	nation							11	Od. Inside (	Diby Limits
	laryla eho	5	PA	Frankli	n	100.01	Green		2						''		s 2 No
	the N	ect	10e. Street and Numbe		. 11		Green	10f. Zip			<u>.</u>		10a Citiza	en of Wha	t Coun		
	with Sa or	Funeral Director		131 Timo	thy Dr				1722.	5			-	.S.A		, .	
	death ms 2:	era	11. Marital Status		12. Was Dec	edent Ever in L	J.S. 13.	Was Deced	ent of His	panic Orig	gin? (Spe	city Yes or No-	14	4. Race - /			
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event. The Madical Examinar must be notified at	ě	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Fr 1 ☐ Yes If Yes, G Year or I	<b>2</b> € No ive		f Yes, spec 1 ☐ Yes 2			i, Puerto I	Rican, etc.)	5	Black, V Specify:			
9	72 ho	Completed		. Decedent's Ed			16a. Dece	ient's Usua kind of wor	l Occupa	tion	of working	200	16b. Kin	d of Busin	ess/Inc	lustry	
21	thin 7	nple	Elementary/Seconda		College (		life.	DO NOT us	e retired)			,g	0-		- 01		
121	led w lygier her th	S	1.2	- A Middle 1 A			As	sembly	y Li			(Fig. 14)		rning	5 61	Lass	
and	nta! H	Be	17. Father's Name (First	st, <i>middi</i> e, <i>Last)</i> arshall	Miller							(First, Middle, Strick1		iumame)			
Z	hould d Me mark matic	5	19a. Informant's Name				19h Mailir	ng Address	(Street a			l Route Numbe		Town Sta	te Zin	Codel	
S	nd 2 s lith arr 27 te r treu			L. Mart		band		_				ncast1e				-	
ē,	s 1 a/ f Hea item othe		20a. Method of Disposit				Place of Dispo cemetery, crer	sition (Nam	e of	)	D	ate	20c. Loc	ation - Cit	y or To	wn, State	
E	Page nent o int: If		1 🔀 Burial 2 □ C  1 4 □ Donation 5 □			State Ced	ar Gro	ve Mei	nnon	ite	6/4/	2012	Gre	encas	stle	e, PA	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tree		21. Signature of Funera	al Service Licen	see mlin	، ملک،	22	. Name and	d Address	s of Facilit		uneral Greenca	Home	Inc	173	225	
			23a. Part1. Enter the d shock, or heart fa	lisease, or comp	olications that	caused the dea								9 1 11	1/2	Approxima Interval Be	ate
	Physician /Medical		Immediate Cause (Findisease or condition resulting in death)		a. CE	CREBRO		uche	. A	eun	ENT	•				Onset and	Death
l.	Examiner					(O) as a consec	_	Lamba	IT7A							Yen	66
	n =	ner	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Disease or inju-	ions, diate	Due to	(or as a consec	quence of):	- 101								70	
	ate be executed hysician and the burial-transit	Examiner	that initiated events		c. #/	HASIL										4 em	25
30,	e execian a	EX	resulting in death) Last		Due to	(or as a consec	quence of):										
8760,	icate b physic s the b	dica			d										-		
Box 6	ath certif titending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 ℚ No	nths?	1 ☐ Live I 4 ☐ Preg	itcome of pregn birth 2 Feta nant at time of c	al death 3	Ectopic pre					23	3d. Date of Month		ry Day	Year
P.0	that the de ned by the a detached t	hys	9 🗆 Unknown <sup>t*</sup>		9□ Unkr												
	w requires tha been signed I should be det	by	Part II. Other significar	nt conditions of	ontributing to c	leath but not res	sulting in the u	nderlying ca	luse give	n in Part I.		23e. Did to	bacco us es 2 🗆		te to th ] Prob		death? ]Unknown
Records,	itcian: The law requ certificate has been rector, page 2 shoult	Completed										24a. Was a autop perfor	sy med?	prio: deat	r to con h?	osy findings	available cause of
ta	an: T tificat tor, pa	Be Co	25. Was case referred	to medical						26 Place	of Death	(Check only or	2 No	1 🗆	Yes	2) No	
of Vital	Physician: this certific ral director,	To B	examiner?	1	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3 DO	A Othe			ne 5 Resid		□Other (	Specify	·)	
ion oi	Attending Ph r death. ector: After th by the funeral	atlon;	27. Manner of Death  1 Natural 5 2 Accident	☐ Pending investigation		of Injury oth, Day Year)	28b. Time of Injury	28 M	3c, Injury Work 1 🗆 Y	at ? es 2 🗆 !		8d. Describe h	ow injury	occurred		,	
Division	al or Attendi after death. I Director: A d in by the fu	Certification;		Could not be determined	280. Place	e of Injury - At h ing, etc. (Speci	ome, farm, str	eet, factory,	office		2	8f. Location (S City or Tow		Number o	r Rura	l Route Nui	mber,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 (Check only one)	Certifying Ph	iner: On the b	e best of my kno basis of examina aner stated.	owledge, death ation and/or in	occurred a vestigation,	at the tim	e, date and inion, dead	d place, a	and due to the o	ause(s) a late and p	ind manne place, and	er as st	ated. the cause(	(s)
	To th within To th	Me	29b. Signature and title	of certifier				29c.	License	number		12	29d. Date	signed (N	fonth, l	Day, Year)	
	,		► HO	28.05	> MO	)			041	556	(		MA	4 2	i	201	2
	(0 km		30. Name and address			se of death (Ite	m 23a) (Type,	Print)									
	Sta	te	31. Date filed (Month, D		01/2 32.F	1190 M	T A ETM	va Re	DIM	4A	GER	STOWN	MD	7	17	40.	
	Registr		JUN 1	1 2012	Beneva	Registrar's Sign	parker										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Month Physician/ Hazel Elizabeth Norris Medical Gity, Town, or Location Facility Name (if not institution, give street and number) 4c. County of Death Examiner 21/2 MAS racq TME If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 04/22/ 9. Birthplace (State or Foreign 7 Age (In yrs. last birthday, **Funeral** Min. Days 1 ☐ M 2 🗶 F Months Hours Maryland 220-24-6201 **Director** 86 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ence. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Havre de Grace XXYes 2 □ No 10f. Zip Code 10e. Street and Numbe United States of 21078 Funeral 320 South Stokes Street America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White Specify: 3

Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Operator ( ) Communication Switchboard Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Vergie G. Sampson Elmer H. Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Aldino-Stepney Rd., Aberdeen, MD 21001 (niece) Susan Ragan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition <sup>20</sup>G Location - City or Town State Havre de Grace, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/30/201**2** Maryland Angel Hill Cmty 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S.Washington St.Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between nset and Death Arte Immediate Cause (Final Physician/ oronal wrs disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 L Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Dehydralion Records. 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performe 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death.
Funeral Director: A leted filled in by the fu Accident Investigation ☐ Accider☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 warn MD 1 32-609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haure De Grace MD 21078 Mithan 1106 Revalution St MUS

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Mont 012 Medical 4a. Facility Name (if not institution, give street and number Examiner top Kins ouns 7. Age (In yrs. last birthday) 35 If Under 1 Year I If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 215 86 0195 0670771976 1 D M 2 D F Director Washington DC i filed within 72 nours enter ital Hygiena. ed other than "neture!" or items 23a or 28a-f show e ovent, the Madical Exception mastice in titled at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No VA Fairfax Falls Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22043 7646 Centerside Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 Ho If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced ar or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 8 permit. Paga 1 and 2 should ba filed Department of Health and Mental Hy important: if item 27 is merked oth any injury or other treumatic event 00029. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ္ Frances Phillips David Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7646 Centerside Court/Falls Church VA 22043 Stephen Robert Wegener/Husband Baltimore, 20a. Method of Disposition

1 → Burial 2 → Cremation 3 → Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State National Memorial Park 06/04/12 Falls Church VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee dvent funeral Services 7211 Lee Hwy/Falls Church VA 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying the attending physicien end thed for use as the buriel-trensit Exam Hospital or Attending Physician: The law requires that the death certificata be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.
with a Funerel Director: After this certificate has been signed by the scompletaly filled in by the funeral director, paga 2 should be deteched. 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 NO 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number RES-000 29d. Date signed (Month, Day, Year) May 28, 20/7 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Orleans St. Baltimore MD, 21287 61655 32. Regist State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar	State of Mar	yland / Depa <i>Cer</i>	artment of H <i>tificate of D</i>	lealth and N Death	/lental Hyg	liene Reg. No. 20	12	18434
	Physicia	n/	Decedent's Name (First, Middle, Last)	· · · · ·				2. Date of Dea Month	th Dav	Year	3. Time of Death
	Medic	al	Louise Helen Ne  4a. Facility Name (if not institution, give stre			4b. City, Town, or	Location of Death	May	20 4c. County	2012	8:00 P M
1	Examin	er	3813 Bayview Rd	et and numbery			ke Beach		Calv		
	Funeral		5. Social Security Number 6. Sex	7. Age (f	n yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/20/	Year)	Count	
	Director		579-14-0887  Usual Residence of Decedent		0,			2/20/.	1923	Washi	ngton, DC
	yland -f sho ed at	ctor	10a. State 10b. County  Md Calvert	1	Oc. City, Town or Loc	ation ake Beach				10	0d. Inside City Limits 1   ✓ Yes 2   No
	he Ma or 28a notif	Director	10e. Street and Number		on obap o	10f. Zip Code	`		10g. Citizen of	What Count	
	s 23a sustbe	Funeral	6111 8th St.			20732			USA		
36	filed within 72 hours after death with the Maryland Hygiene.  4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	o If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - America ck, White, e	etc.
9-0	hours natura dical E	olete	15. Decedent's Educa (Specify only highest grade of	ation		ent's Usual Occupa		ing	16b. Kind of B	lusiness Ind	ustry
Maryland 21215-0036	thin 72 ene. than ' he Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	not won done do NOT use retired) retary	anny most or work	- 1	Montgo High Sc	mery 1	Blair
ر ام	filed wi al Hygie d other event, t	Be	17. Father's Name (First, Middle, Last)	<del></del>	1 560.	lecary	18. Mother's Nam				
ylar	should be file n and Mental I is marked o raumatic eve	욘	George Yazge		- 1		Matild	a Betar			
Mar	2 shouth and the strand traum		19a. Informant's Name/Relationship (Type,			g Address (Street a					ode)
	1 and of Heal item	1	Debra Bowman / Date 20a. Method of Disposition	_	20b. Place of Dispos	8th St. C sition (Name of natory or other place		Date	20c. Location		wn, State
Baltimore,	. Page tment o tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Red 4 ☐ Donation 5 ☐ Other (Specify)		Ft. Linco	ln Cemete	ry 5/2	6/12	Brentwe		
Ball	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.	vil	21. Signature of Funeral Service Licensee		3	Name and Addres	ensburg R	Rd Bren	twood,		ome 0722
1	mysician/ Medical Examiner		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)		spiratory		g, such as cardiac (	or respiratory arre	981,		Approximate Interval Between Onset and Death  days
09		dical Examiner	Sequentially list conditions, if arty, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence or):  c.  Due to (or as a consequence of):  d.								
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	If yes, outcome of 1  Live Birth 2 4  Pregnant at ti 9  Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy	у			ate of delive	ery Day Year
s, P.O	ires that the signed by Id be detact	d by Pr	Part II. Other significant conditions contri Alzheimer's	ibuting to death but	not resulting in the u	nderlying cause giv	en in Part I.				e cause of death?
Secord	The law requate has beer bage 2 shou	omplete	Dementia					24a. Was a autop perfor	sy med?		osy findings available inpletion of cause of
ta	cian: sertifica ector, p	Be	25. Was case referred to medical examiner?	pital:		26. Pla	ace of Death (Chec	k only one)			
n of Vi	nding Physi th. After this of funeral dire	cate: To	1 ☐ Yes 2 🕱 No  27. Manner of Death  1 🛣 Natural 5 ☐ Pending 2 ☐ Accident Investigation	1 ☐ Inpatien 28a. Date of injury (Month, Day,	t 2 ER/Outpatien 28b. Time of injury	28c. Injury work'	at Nursing H	ome 5X Resid 28d. Describe ho			
Divisio	tal or Atter s after dea al Director ed in by the	I Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)	eet, factory, office		28f. Location (S City or Town		er or Rural	Route Number,
_	the Hospil nin 24 hour the Funera npleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physicia    2 Medical Examiner   3 Certifying Nurse P	: On the basis of exa	mination and/or invest	igation, in my opinio leath occurred at the	n, death occurred a e time, date and pla	t the time, date ar ce, and due to the	nd place, and du cause(s) and m	ie to the cau	use(s) and manner stated. ated.
	± 25 €		29b. Signature and title of certifier			_	1942	7	29d. Date signe		
	JA.		30. Name and address of person who com 130 Hospital Rd. S	pleted cause of dea <b>uite 300</b>	th (Item 23a) (Type, F	<sup>rint)</sup> Dr. Anv rederick.	var T. Mu Md 206				
i	Sta Registr		31. Date filed (Month, Day, Year)  AAY 2 4 2012		s Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 18435 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ois May U150 2072 11:23a M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12500 Blake Road Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 578-26-2969 1 □ M 2 🔏 F 86 08/11/1925 Illinois Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12500 Blake Road 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Huesman Raymond Wiegand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Landi - Daughter 12500 Blake Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Culpeper Natl. Cem. 05/29/2012 | Culpeper, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Kath 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 0/01 disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)

Physician/ Medical **Examiner** 

þ

certificate has

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the Hospital or Attending

Physician/

Medical

**Examiner** 

**Funeral** 

Director

28a-f show

ō

ō

"natural"

Il Hygiene.

of Health and Mental H fitem 27 is marked ot r other traumatic even

Department of Health ar Important: If item 27 is any injury or other trau

Medical

the

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

ms 23a or must be

notified at

Director

Funeral

ģ

Completed

Be

ပ

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Completed by

Be

Certificate:

Medical

29a. Certifier

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last

in the past 12 months?

25. Was case referred to medical

1 Yes 2 9 Unknown

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death

g Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_

23d. Date of delivery Month Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia.

Pregnant at time of death

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an performe

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number D31001 5/22/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Kerritz

7500 Greenway Colr. Dr. #430 Greenbelt, MD

State Registrar 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY NORMA KATE PARKER 2012 11:41 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** WALTER REED NATIONAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗡 F Months Hours Min AMADAMA Director -30 Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified PRINGFIELD 28a-f 1 Tes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or 5563 EASTON items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. "natural", or iten ledical Examiner r 11. Marital Status 14. Race - American Indian. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 2 No 1 Yes Specify Specify. 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 0W4 Home Homemaker ed other I event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked ot other traumatic ever ပ AUEN 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPRING Department of Health Important: If item 27 any injury or other tronce. Parker/Husbaro ERNEST EASTON Dr. 23MA 550 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, Removal from State FAITFAX 21. Signature of Funeral Service Licen 5308 CC0517 Demaine 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition VENTILATORY FAILURE resulting in death) Medical Examiner UPPER GASTROINTESTINAL BLEED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (c) as a consequence oil Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial-t attending physician Physician/Medical Records, P.O. Box 68760 the use as yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ğ 5 Other (specify) Month Day Year Pregnant at time of death the ; 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? cate has by page 2 s certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de

To the Funeral Directo

completed filled in by the 4 Homicide determined Medical 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2 MD036483 10 DC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL

Registrar

State

MASSOUMI,

MD

24 2012

2. Registrar's Signature

BETHESDA, MD 20889

CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8437 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Gary Papich 1330 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Director 220-70-3146 1 🗶 M 2 □ F May 10, 1954 Washington, DC 58 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Completed by Funeral Director Gaithersburg 1 Yes 2 No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20877 205 Meadowgate Terrace ural", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Ith and Mental Hygiene.
27 is marked other than "natural", traumatic event, the Medical Exar Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Verizon Lineman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file n and Mental H 7 is marked o ဂ Ann Frascarelli Samuel Papich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Meadowgate Terrace, Gaithersburg, Maryland20877 permit. Page 1 and 2 s Department of Health 27 Pamela Papich - Spouse item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 💢 Burial 2 🗆 Cremation 3 🗎 Removal from State 05/24/2012 | Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) VOCANCE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 🔪 No 1 Yes 2 No the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 1 Inpatient 2 KER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville MD 20850

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

24 2012

12012

30/

05

Gary

9901

32. Registrar's Signature

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar  1. Decedent's Name (First, Middle, Last)	,	Certificate of E		2 Date of Dea	Reg. No. 2012	3. Time of Death	
	Physicia Medio		Leonora Webb Richardson	ı			Month May	21°, 2012°	10:35pm	
	Examin		4a. Facility Name (if not institution, give street and nu Summit Park Health and I			Location of Death		4c. County of Death <b>Baltimore</b>		
1	Funeral Director		5. Social Security Number 6. Sex 1 M 2 x F	7. Age (In yrs. last birth	oday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth April 1	9. Bi B <sup>Year)</sup> 1921 <b>A1a</b>	rthplace (State or Foreign puntry) <b>bama</b>	
	and show dat	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town					10d. Inside City Limits	
	e Mary r 28a-f notifie	Director	DC  10e. Street and Number	Washi	ngton  10f. Zip Code			10g. Citizen of What C	1 ★ Yes 2 No	
	with the 23a o	Funeral [	44 Allison Street, N.	W.	20011			United St		
020	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	by	Armed F	2 🔀 No ve	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗶 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify <b>Afr</b>	te, etc.	
0-0	"natu edical	Completed	15. Decedent's Education (Specify only highest grade completed	f)	Decedent's Usual Occup (Give kind of work done of	ation during most of work	ing	16b. Kind of Business		
21213-0030	within 7 giene.		Elementary/Seconday (0-12) College (	1-4 or 5+)	life. DO NOT use retired)  Analyst			Federal G	overnment	
Maryland	e filed vital Hyged other	To Be	17. Father's Name (First, Middle, Last)  Cager W. Webb			18. Mother's Nam				
aryie	ge 1 and 2 should be fili it of Health and Mental If item 27 is marked o or other traumatic eve	=	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street a		ie Myer: al Route Number		lip Code)	
	and 2 sh Health a em 27 is ther trai		Dr. Joyce P. Webb- Sist		10 Wine Ber					
baltimore,	age 1 and int of Hea t: If item / or other		20a. Method of Disposition  1 🛣 Burial 2 🗆 Cremation 3 🗎 Removal from	n State cemeter	Disposition (Name of y, crematory or other place	:e)	Date	20c. Location - City o		
all	permit. Page 1 a Department of H Important: If ite any injury or ot		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	ROCK	Creek Cemete 22. Name and Addres	ery : 5/24 ss of Facility McG	uire Fu	Washington neral Serv	. D.C. ice. Inc.	
מ	8 <b>3 E</b> 8	10	Indre Tho	pse	7400 Georg	ia Ave.,	N.W. Was	sh., D.C.	20012	
	hysician/ Medical	í	23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a limmediate Cause (Final disease or condition resulting in death)	ach line.	rotic Cardi				Approximate Interval Between Onset and Death	
	Examiner	<u>_</u>	Sequentially list conditions, b.	Advanced De						
	ted Pair	Examiner	cause. Enter Underlying Cause (Disease or iinjury	(cras a consequente o	C-					
	cate be executed physician and sthe but at tension		that initiated events resulting in death) Last C. Due to	(or as a consequence o	of):		_			
20	icate be executed in physician and sthe build report	edical	d			· <u>-</u>				
DOX DO	sician; The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/M	in the past 12 months?	utcome of pregnancy Birth 2  Fetal death gnant at time of death known	3 Ectopic pregnanc 5 Other (specify)	су		23d. Date of d Month	elivery Day Year	
ŗ.	that the ned by detac	by Ph	Part II. Other significant conditions contributing to	death but not resulting in	n the underlying cause given	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
ds,	squires sen sign ould be						1 🗆 1		Probably 4 🗌 Unknown	
ğ	The law recate has b	Completed					24a, Was a autop perfor 1 \(\sum \) Yes	rmed? prior to death?	utopsy findings available ocompletion of cause of es 2	
Ital	sician; certific irector,	Be c	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \mathbb{X} \) No  Hospital:	]	Oth	ace of Death (Chec		0 0 0 0 0 0	-16.)	
010	ng Physter this neral d	te: To	27. Manner of Death 28a. Dat	Inpatient 2 ER/Oute of injury 28b. To the nth, Day, Year)		y at		ence 6 Other (Spectron) occurred	ecity)	
Slon	ttendir death. stor: Af the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At home, far	M 1 □	Yes 2 ☐ No	28f Location /S	treet and Number or R	ural Route Number	
Š	tal or A		4 Homicide determined	ding, etc. (Specify)	m, oneon, ractory, omeo		City or Tow	n, State)	area reacto rearmout,	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the b	asis of examination and/or	r investigation, in my opinio	on, death occurred a	t the time, date a	nd place, and due to the	e cause(s) and manner stated.	
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practione  29b. Signature and title of certifier	1	edge, death occurred at the			29d. Date signed (Mon		
	5		> 50a		D300	641	14.	ay 22, 201	2	
			30. Name and address of person who completed ca Ramesh Sabapathi, M.D.		Type, Print) lack River l	Neck Road	, Balti	more, MD 2	1221	
ξ	Sta Registr		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	als.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month Day  $2012^{\text{Year}}$ Physician/ 23 12:10p M Jane Dayton Richardson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 89 215-12-6628 1 🗆 M 2 🗶 F Director Delaware June 15, 1922 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Funeral Director -28a-f MD Dorchester Cambridge 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a 5414 Cannon Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examia one. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) clerical retail store Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Richard C. Dayton Ethel Gill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronnie Richardson 5414 Cannon Road, Cambridge, MD 21613 son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 5/26/12 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. asma 700 Locust St., Cambridge, MD 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Obstructive pelnong Immediate Cause (Final Stace Physician/ disease or condition Medical resulting in death) Due to (or as a consed lence of): **Examiner** ulmoher Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performed death? Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Mann Death 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ≰eftifier 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Registrar's Signat

BYRN ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Etha Patricia Rickwood Month 2 Day Year mai 0738 AM 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death astor Memorial Hospital at Easton Talbot Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Director 217-30-9856 1 □ M 2 🗓 F 79 Mar. 18,1933 Maryland item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Dorchester Maryland East New Market 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3930 East New Market Bypass 21631 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "na
eny injury or other traumatic event, the Medic 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Bookkeeper School Bus Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Walter Bloodsworth Edna Bounds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21631 William Vernon Rickwood/Husband 3930 East New Market Bypass, East New Market MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/26/2012 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. East New Market, MD 21. Signature of Juneral Service 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 hock, or heart failure. List only one calls a. Part 1. Enter the disease, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Due to (or as a consumence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Hospital or Attending Physicien: The law requires that the deeth certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Month Day ed by the at detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 Yes 2 No Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No ▶ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred A Natural 5 - Pending 1 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2012 0 who completed cause of death (Item 23a) (Type, Print) . Name and address of person 2160 TOX

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

MAY 24

Kickwood,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BEVERLY ANN ROBINSON PM 35 410 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 213-42-7358 70 Director 1 🗆 M 2 🕱 F Yrs 11/16/1941 Washington, DC 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a. State Director notified MD PRINCE GEORGE'S CAPITOL HEIGHTS 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n ö Funeral 619 BIRCHLEAF AVENUE 20743 USA rral", or items ? death 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinone. <u>ک</u> 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE EXHIBIT SPECIALIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SARAH PROCTOR SYLVESTER M. ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 BIRCHLEAF AVENUE, CAPITOL HEIGHTS, MD 20743 BENJAMIN SINGLETON, SR./COMPANION 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State NATIONAL HARMONY CEMETERY : 05/22/2012 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME Signature of Funeral Service Icen 716 KENNEDY STREET, NW, WASHINGTON, DC 20011 23a. Part 1. Enter the disease shock, or heart failure. dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oman Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Unionying Cause (Disease or injury Due to (or as a consequence of) the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Month Pregnant at time of death Unknown g Unknown signed by 1 Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 **V**No Hospital 1 Tyes မ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury Manner of De th 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No (Month, Day, Year) injury 1 2 Natural 5 Pending ☐ Accident Investigation the 24 hours after death Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 1 💯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

HOSPITAL

DRIVE

3001

32. Registrar's

CHEVELLY

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Physician/ Month May 13, 22:45 Theodore Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛣 M 2 □ Months Days Hours Min (Month, Day, Year) an 24 1941 Director Jan. 577-54-5810 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 x Yes 2 No Adelphi Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 United States 1801 Metzerott Road items ( 12. Was Decedent Ever in U.S. Armed Forces?

1 ♣Yes 2 □ No If Yes, Give "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: African American Completed 3 Widowed 4 Divorced Year or Dates er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Hygiene. Private Custodian is marked other Be Page 1 and 2 should be filed ament of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Coleman Mahilda Rich 19a. Informant's Name/Relationship (Type, Print) 20020 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1625 Gainesville Street SE #202 Washington, DC Rita Washington - Cousin item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 5. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee's Crematory 4 Donation 5 Other (Specify) 2012 Clinton, Maryland 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Lic see M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between OLYJCO Onset and Death Immediate Cause (Final Physician/ SIGHUOUD disease or condition resulting in death) Medical Due to (or as a consequence of) 154ASL Examiner 2KINSID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit 4MWTH Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death 2 🗌 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ST TAC SUTEN 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifies Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0044957 2012

State Registrar 30. Name and address of person who completed caus

Wagner

Randall P.

7600

Unit 1500

Takoma Park, Maryland

of death (Item 23a) (Type, Print)

Carroll Avenue

			- State AMEND#19a p	er FH TT 5/3	30/ <i>Car</i>	tificate of l	Death			Reg. N	0.			
			1. Decedent's Name (First, Middle, Last	)					Date of De			$\Box$	3. Time of Dea	ıth
	Physicia Medic		CALVIN	REVELLE	SI	R.			${\stackrel{ m Month}{ m MAY}}$	20	0, 20	12	11:55	$\mathbf{P}^{M}$
	Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, o	r Location of	Death		4	c. County of De	ath		
			8106 HAYFIELD COU	JRT .		CLINTO	N			] ]	PRINCE	GEO	RGE 'S	
	Funeral		Social Security Number     6. Se	3-()	st birthday)	If Under 1 Year Months Days	If Under 24 Hours		Date of Bir (Month, Da		9. E	irthple	ace (State or Fo.	reign
	Director			X M 2 □ F   62	Yrs.	Widitins Days	Hours		arch			Country RTH	CAROLI	NA
	t ow	_	Usual Residence of Decedent  10a. State 10b. County	10- 0:5	, Town or Loc									
	yland -f sh ed a	cto	,			сацоп						100	d. Inside City Li	
	28a otifi	Funeral Director	MD PRINCE G	EORGE'S CL	INTON							丄	1 X Yes 2	_ No
	h the	al	10e. Street and Number	<b>™</b>		10f. Zip Code	-				citizen of What (	Countr	y?	
	filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ner	8106 HAYFIELD COU			2073				USA	A			
	deal		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 Xyes 2 NoAirf		Vas Decedent of H Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)	'	14. Race - An Black, Wh			
3	after II", o	Completed by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 LAYes 2 □ Non LI	10146	Yes 2 No	Specify:					BLA		
9500-61212	ours atura	etec	15. Decedent's Ed	Year or Dates.		ent's Usual Occup								
င်	n "na Aedio	ldu	(Specify only highest grad	de completed)	(Give k	rind of work done ( O NOT use retired)	during most o	of working		16b. I	Kind of Busines	s/Indu	stry	
7	ithin ene. r tha	Cor	Elementary/Secondary (0-12)	College (1-4 or 5+)		RITY SPE.		зт			GOVE	RNM	ENT	
	filed wal Hygi al Hygi dother	Be	17. Father's Name (First, Middle, Last)	<u> </u>	DECC.	KIII DIL		's Name (Fi	rst. Middle.	Maider				
a	be fill ked (	일	CLARENCE R. OUTLA	AW SR				GARET		ELL	,			
₹	should I and Me		19a. Informanischame Zehnionship (Typ		10h Mailin	a A alaba a a /Chua a A						Zin Co	ala)	
Maryland			BRENDA REVELLE/WI			g Address (Street HAYFIEL)							735	
	and Heigh		20a. Method of Disposition		ace of Disnos	sition (Name of		Date	,	200 1	Location - City	or Tow	n State	
وَ			1 🖾 Burial 2 □ Cremation 3 □	Removal from State C6	emetery, crem	atory or other plac								
=======================================	rtme rtani rtani		4 Donation 5 Other (Specify			NS CEMET					LTENHAM			)
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	1 or andino		Name and Addre							•	.0.
			200 Sept 1 Show the disease are area	tioning that are add the death		474 LAND					LLE, MA			00
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on		i. Do not ente	r the mode of dylr	ig, such as ca	ardiac or re	spiratory ar	rest,		i i	Approximate nterval Betweer	
	thyracian/		Immediate Cause (Final disease or condition	a HEPATOCELLU	LAR CA	RCINOMA							Onset and Deat	.1
A.	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):									
		Į.	Sequentially list conditions,	b. HEPATIC CIRI								<u>.                                    </u>		
	p ji	nine	If any, leading to immediate cause. Enter Underlying	ESOPHAGEAL	VARTCE:	S						1		
	executed an and rial-transi	Examiner	Cause (Disease or injury that initiated events	c. Due to (or as a conseque								$\vdash$		
	e exe		resulting in death) Last	HEPATIC FAI	LURE W	ITH ENCE	PHALOP	ATHY						
8/60	certificate be executed nding physician and use as the burial-transit	/Medical		d								+		
ά	± σ α = 1	/Me	IF FEMALE:	20.0 16										
×	sician: The law requires that the death certi certificate has been signed by the attendin rector, page 2 should be detached for use	Physician	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal	death 3		су			- 1	23d. Date of c		y Day Year	
ROX	death the atte	sic	1 Yes 2 No 9 Unknown	<ul><li>4 ☐ Pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of degree of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnan</li></ul>	eath 5 □	Other (specify)					WOITH	U	ay Toai	
л Э	at the	Ph	Part II. Other significant conditions co	ntributing to death but not resu	ıltina in the ur	nderlying cause gi	ven in Part I		23a Did t	obacco	use contribute	to the	cause of death	2
J.	es the	by	Turkin other eiginiodik opridicione ee	minuting to dodin but not look	itting iii tiro tir	naony mg baabb gi								
Sp	een s een s oould	Completed						-	1 🗆	res 2	2 🗓 No 3 🗆			
<del>ပ</del>	aw reas be	βdτ							24a. Was auto	psy	prior to	o comp	y findings availa pletion of cause	able of
Ě	The I ate h page	Son							perfo	ormed?	death?		□ No	
DIVISION OF VITAL RECORDS,	sian:	Be (	25. Was case referred to medical examiner?	- Company			lace of Death	(Check on	ly one)	71	No. at reference for			
5	hysic nis ce	은	1 Yes 2 X No	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	t 3 🗆 DOA Oth	er: 4 🗌 Nurs	sing Home	5 😿 Resi	dence	6 🗆 Other (Spe	ecify)		
o	ng Pl		27. Manner of Death 1   Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work		28d	. Describe I	how inju	iry occurred			
0	endir sath. or; Af he fu	fica	2 Accident Investigation				Yes 2 1	No						
<u> S</u>	er de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office		28f.	Location (S		nd Number or F	lural R	oute Number,	
É	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director, After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detach			Sananig, etc. (Operaty)				- 2	Oity Of YOV	vii, Otati	5)			
	osbi hon uner	Medical	29a. Certifier 1 Certifying Physi	ician: To the best of my knowle ner: On the basis of examination	edge, death o	ccurred at the tim	e, date and p	olace, and c	lue to the c	ause(s)	and manner as	stated	(a) and manner	ototos
	he H in 24 he F	Me	(Check 2 Medical Examir only one) 3 Certifying Nurse	e Practitioner: To the best of m	y knowledge,	death occurred at	the time, date	and place,	and due to	the caus	se(s) and manner	as sta	ited.	Statet
	Not To To To To To To To To To To To To To		29b. Signature and title of certifier	all N		29c. Licens	e number			29d. Da	ate signed (Mor	nth, Da	ıy, Year)	
	ĺĎ		Clames 7	Julia M	>	D414	22			ŀ	MAY 21,	20	)12	
	ar		30. Name and address of person who co		23a) (Type, Pi		-							
	•		DR. JAMES GRIFFIN			rk Cente	r Dr.	#102,	Laur	e1,	Maryla:	nd	20707	
	Stat		31. Date filed (Month, Day, Year)	32. Registra 's Signa	are de la la la la la la la la la la la la la									
	- /6 (a) (C) //	:17												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 13, 10:35 AM 2012 May Physician/ Walter Howell Smead Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) Social Security Number 1937 Massachusetts (Month, Day, Yea Hours **Funeral** Months Days 1XXM 2 🗆 75 020-28-0519 **Director** Usual Residence of Decedent 10d. Inside City Limits City, Town or Location show 10b. County with the Maryland notified at Director Thurmont 1 X Yes 2 No Frederick Maryland 28a-f 10g. Citizen of What Country? 10f Zin Code 10e Street and Number USA ö ems 23a or 21788 Funeral 102 Locust Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items ? death v 12. Was Decedent Ever in U.S Black, White, etc 11 Marital Status Armed Forces? 1XXYes 2 □ No ortant: If item 27 is marked other than "natural", or ite injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married White ò 1 Yes 2XXNo Specify: Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Furniture Store Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Salesman 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental His Important: If item 27 is marked oth any injury or other traumation 17. Father's Name (First, Middle, Last) Eleanor Morgan ပ Kenneth Smead 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 102 Locust Drive, Thurmont, Maryland Eugene Smead- Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Frederick, Maryland 1 Burial 2XXCremation 3 Removal from State 5-16-2012 Stauffer Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sign re of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death placement Immediate Cause (Final Hor Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transil Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 2 No 1 Yes page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? been 24a. Was an autopsy this certificate has 2 🗌 No Yes 2 1 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 1 🗌 Yes မ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: injury Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director; Ai completed filled in by the fu Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD-435455

(x)

Registrar

Sakeda V
31. Date filed (Month, Day, Year)

MAY 2 3 2012

32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

37 N 5th St. Cettysburg, PA 17325

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Imothy Sasser	1- For State Registrar		State of Maryl	•	artment o rtificate o		nd Mental I		Reg. No. 20	)12 184	4
Physiciar Medical Examin	.,	t's Name (First, Mic ${ m thy}$ ${ m M}$ .		r				2. Date of De Month May 21,	Day Yea	3. Time of Death 1232 hrs	
		Name (if not institu	tion, give street and nu	umber)		4b. City, Town, o	r Location of Dea		4c. County of Montgon		
Funeral		ecurity Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	ar If Under 24H			9. Birthplace (State or Foreign	
Director		6-2473	1 M 2 F	61	Yrs	Months Day	ys Hours M		3, 1950	Country) KS	_
w any	10a. State	10b. Count	у	10c. City,	Town or Locat	ion			=	10d. Inside City Lir	
Aaryland 28a-f show 1 at ouce.	10e. Street	ID and Number	Montgomer	у	SIlver	Spring			10g. Citizen of Wh	1 Yes 2 X	No
the Ma 3a or 28		lton Hea	d Court			20	905		USA		
and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene.  tran 27 is marked other than "natural", or items 23a or 28a-f should the manaite event, the Medical Examiner must be notified at once.	11. Marital	Status er Married 2 🔀	Married Armed F			s Decedent of Hi es, specify Cuba	ispanic Origin? ( & n, Mexican, Puert	Specify Yes or N o Rican, etc.)	o- 14. Race White	- American Indian, Black, e, etc.	
s after d			1 Yes livorced If Yes, Give Yes or Dates:			Yes 2 No			Specify:W		
72 hour n "natu	Elementa	ent's Education (Sp iry/Secondary (0-12	pecify only highest grad 2) College (1				ation (Give kind of e. DO NOT use re		16b. Kind of Bus	siness/Industry	
-003( I within griene. ther tha	Elementa 17. Father's	Name (First, Midd	e Last)	4	Insu	rance Br		ne (First Middle	Insur		
21215-0036 Suld be filed within 7 Mental Hygiene. Marked other than c event, the Medica	Alfr	ed Sasse	r Jr.		un en en en en en en en en en en en en en		Betty	Anne Be	rgstress	er	
7 3 5 5 S F	-	ant's Name/Relation Lee Sass			1.2				mber, City or Town	n, State, Zip Code)  MD 20905	
Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If iteu 27 in jury or other traumat.		of Disposition	on 3 Removal fr	om State	Place of Dispos prematory or oth	ition (Name of ce ner place)	metery,	Date ay 23,		City or Town, State	
Itime nit. Page artment ortant: ry or ot		ation 5 Other		Met		an Crema	atory	2012	Alexand	iria, VA	_
	10	was of	Park		Poo	univers	sith Riv	d. W.,	l Home In Silver Sp	oring, MD 209	
Physician	failurè.	Enter the disease, on List only one caus Cause (Final diseas						or respiratory an	rest, shock, or hea	Approximate Inter Between Onset a Death	
Examiner		resulting in death)		consequence of		ovacoula. Bi	50450				
	Sequentially if any, leading cause. Enter	r list conditions, ng to immediate er Underlying Caus	A	consequence of	r):					13	
ist. A se	(Disease or events resu	injury that initiated iting in death) Last	C	consequence of	):						
00, e be exeguted systian and burial - ransit	UNPE	NDED	d AMENDED		<u> </u>						
		cedent pregnant in	23c. If yes, of	outcome of pregr		al death 3	Ectopic pregn	ancy	23d. Date of d	delivery  Day  Year	
box 68760, the death certificate be exeguted the attending physician and ched for use as the burial - transit	past 12	months? 2 No 9 U		ant at time of dea	oth -	ner (Specify)			World	Day Teal	
	Part II. Othe	r significant cond			sulting in the u	nderlying cause (	given in Part I.			oute to the cause of death?	_
rds, P.C requires that been signed hould be deta							-	1 Ye		Probably 4  Unknown	
of Vital Records, 1sg Physician: The law requires ther this certificate has been signeral director, page 2 should be 17 Re Completed.								autor perfo 1 <b>✓</b> Yes	osy pri rmed? de	nor to completion of cause of eath?  Yes 2 No	
Vital Rec yrician: The l his certificate l director, page		e referred to medic	- Hospital:				of Death (Check	only one)			
ing Physic ling Physic After this funeral dir	27 Manner	of Death	28a. Date (Month,		ER/Outpatient 28b. Time of In	0 00.1	ry at Work?		Residence 6 V		_
Division of ital or Attending are after death.  ral Director: After lied in by the fune lied in by the fune entitication:	1 V Natu 2 Accid	dent Inve	nding estigation		me form street	1 1	Yes 2 No	29f Location (	Chanat and Musshau	and Devel Development of the	
Divis spital or At nours after d acral Direc filled in by		icide dete	uld not be ermined (Specify)	o or injury - Actio	me, jam, street	, raciory, ornes b	dilding, etc.	or Town, S		r or Rural Route Number, Ci	ty
Division  To the Hospital or Attent  To the Funeral Director: Completely filled in by the	_   29a. Centile	Certifying i	Physician: To the besi aminer: On the basis of	f examination an							
L C C C C C C C C C C C C C C C C C C C	29b. Signatu	re and title of certif	and manner st	ated.		29c. Licens			29d. Date signed	d (Month, Day, Year)	_
4	30 Name on	d address of person	Modern who completed caus	e of death (Item	23a)	O.C.I	M.E.		May 22, 201	2	_
	Zabiull	ah Ali, M.D.	Assistant Medica	al Examiner	900 W. Ba	and a	et, Baltimore,	MD 21223			
Stat Registra	e 31. Date file	Month, Bay Year	012 Sensu	gistrar's Signatúr	face	Ø.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 12, 2012 Myrtle Rita Smith 3:37 рМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 625 River Bend Road Fort Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral Director** 578-24-7571 1 □ M 2 🔀 F May 25, 1918 Louisiana 93 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Fort Washington 1 X Yes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 625 River Bend Road 20744 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "natural", If Yes, Give 3 X Widowed 4 □ Divorced Specify: Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th 12 years Housewife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ortant: If Item 27 is marke injury or other traumatic Nicholas Zeno Charlotte Pierre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Clark - Daughter Old 125 Road Halifax, NC 27839 Baltimore, Important: If iten 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Page Cedar Hill Cemetery May 22, 2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Renal Failure Medical resulting in death) Examiner Hypertension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Pregnant at time of death 5 Other (specify) Month Day Year 2 X No g Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 💢 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. I Director: Aft ed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4,0 D50348 May 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

State Registrar

Crystal P. Yeldell

Suitland, Maryland

5100 Authway

32. Regist

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ouglas Scott	1- For State Registrar	Certificate	of Health and Mental of Death		eg. No. 201	2 1844
Physician Medical Examina	Decedent's Name (First, Middle, Last)			2. Date of Deal Month May 30, 2		3. Time of Death 0522 hrs
noulcai Examine	4a. Facility Name (if not institution, give street and number	)	4b. City, Town, or Location of De		4c. County of Dea	
	University Hospital		Baltimore			
Funeral Director	228-54-4624 1XM 2 F	ge (In yrs. last birthday) 69 Yı		8. Date of Bin 112/28/	Fore	irthplace (State or ign Washingtor country) DC
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits
E	Virginia Fairfax	Annandale				1 Yes 2 X No
the Maryland tor 28a-f sh iffied at one	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Co	untry?
with the is 23a or e notific		I I I I I I I I I I I I I I I I I I I	22003		USA	
er death w	11. Marital Status  12. Was Decedent Armed Forces'  Married  13. Was Decedent Armed Forces'		as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue		White, etc.	rican Indian, Black,
s after d		1 _	Yes 2 X No specify:		Specify: Wh	ite
hours natur		during	ent's Usual Occupation (Give kind o most of working life. DO NOT use r		16b. Kind of Business	/Industry
5-0036 ed within 72 hour sygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+	Econor	mist		Federal Go	overnment
				me (First, Middle, N		
121 Id be fill fental I		I 40b Moiti	Rosa1		inia Funck	7: 0 1:
AD 21 2 should 27 is ma matic or	Christopher Scott - son	- 1	B. Woodstock St.			
Te, No. 1 and Health	20a. Method of Disposition	20b. Place of Dispo	sition (Name of cemetery,	Date	20c. Location - City o	
Pages nent of nent: I	1 X Burial 2 Cremation 3 Removal from St. 4 Donation 5 Other Specify	Bethel Ce	emetery 06	/11/2012	Alexandria	a, VA
3alti ermit. Separtu mport	21. Sig Funeral Service ee		Name and Address of Facility A			
Physician	23a. Part ( Fint ) the sease, or complications that caused		11 Lee Highway the mode of dying, such as cardiac			2046 Approximate Interval
/Medical	failure List only one suse on each line.		clerotic Cardiov			Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a conse		January Garago,	dbeard:	DIBCUBC	
5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):				
ed nsit <b>Exam</b> lher	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  C.  Due to (or as a const	equence of):				-
ecuted and transit		squarior ory.				
<u>S</u> = = S	▼ UNPENDED	,pt.II,27,p	er me,g930 8-14-	-12 sm		
Box 68760, each certificate be death certificate be the attending physic of for use as the burnsician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth		etal death 3 Ectopic preg	nancy	23d. Date of deliver	y Day Year
ox 6876 eath certificate attending phy for use as the	past 12 months?  4 Pregnant at  1 Yes 2 No 9 Unknown	time of death	ther (Specify)		Monar	Suy Toul
). Box 6876 the death certificate by the attending phyched for use as the Physician/N	Part II. Other significant conditions contributing to death	h but not resulting in the	underlying cause given in Part I	23e Did tol	pacco use contribute to	the cause of death?
ires that the signed by I be detac	Dishetes Mollitus	That the tree data is given and	andonying sauce given in rain.			bably 4 🗹 Unknown
of Vital Records,  by Physician: The law requirer ther this certificate has been signeral director, page 2 should b  n: To Be Completed				24a. Was a		utopsy findings available completion of cause of
he law ate has age 2 s				perform	ned? death?	
tal Reician: The certificate rector, page	25. Was case referred to medical		26.Place of Death (Chec	k only one)		
Physic Physic arthis ral dire	1 V yes 2 No Poste 1 I Inpatie			sing Home 5 F	Residence 6 Othe	r:
Division o spital or Attending tours after death.  neral Director: After filled in by the fune Certification:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Inju (Month, Day,Y)	ear)	1 Yes 2 No	20d. Describe III	ow injury occurred	
Division tal or Attendii rs after death. al Director: A led in by the fi ertification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, stre	et, factory, office building, etc.			ural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	4 Homicide determined (Specify)			or Town, St	ate)	
	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner:On the basis of examiner.					
To the within To the comple	29b. Signature and title of certifier		29c, License number		29d. Date signed (Mo	
	Wh.		O.C.M.E.		May 31, 2012	·
'	30. Name and address of person who completed cause of d Ling Li, MD Assistant Medical Examiner		re Street, Baltimore, MD 2	1223		
State	31. Date filed (Month, Day, Year) 32. Registra	de Cionatido				
Registra		- And				

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Edward Sutton State of Maryland / Department of Health and Mental Hygiene 2012 18448 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day May 24, 2012 Medical Examine 1725 hrs James Edward Sutton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5817 Woodland Drive Oxon Hill Prince George's 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Months Days Director Hours Min 578-58-1908 1 X M 2 F Yrs South Carolina 67 June 10 1944 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 X Yes 2 No Maryland Prince George's t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene.

The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th Forest Heights rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5817 Woodland Drive 20745 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married White, etc. 2 X No 1 Yes African 4 X Divorced 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: Specify: Š American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pe during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>pet</u> Itimore, MD 21215-0036 10th HouseKeeping Private Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ed Sutton Minnie Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2925 Ariel Court Tanja R. Brown - Daughter Waldorf, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) June 5, 2012 Donation 5 Other Specify. Heritage Cemetery Waldorf, Maryland permit. 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licen towar tru (-M00560 Washington, DC 4001 Benning Road NE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death aPontine Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a, 27, per me, g928 6-22-12 sm Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Completed r this certificate has been s al director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ication: 1 X Natural 5 Pending 1 Yes 2 No death. 2 \_\_\_ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Certifi 3 Suicide 6 Could not be or Town, State) within 24 hours a determined the Hospital 4 Homicide 29a. Certifier 1 Certifying Phystcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 25, 2012 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year, 32. Registrar's Signature State detto Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. T- State of Maryland / Department of Health and Mental Hygiene physician 6/5/12 certificate of Death

Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 300 / 12 Year Month 5/ Physician/ Jose Antonio Santa Cruz 03/30/201 5.08 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville Prince Georges 7408 Hendricks Drive If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) ecurity Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months 224-29-5370 **Director** 1 XM 2 - F 64 Bolivia 10/27/1947 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No <u>Hyattsville</u> Maryland Prince Georges 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? other than "natural", or items 23a or Funeral 20784 USA 7408 Hendricks Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married þ Yes 2 XNo 1 X Yes 2 □ No Specify: Bolivian Maryland 21215-0036 If Yes, Give Specify. White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Westin Hotels Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of မ Bertha Saavedra Jose Andres Santa Cruz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>7408 Hendricks Drive Hyattsville, MD 20784</u> Santa Cruz (wife) Baltimore, Anna 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 06/04/2012 Beltsville, Maryland 22. Name and Address of Facility Rendon/Hale Funeral Home Signature of Ineral Service Licensee MA 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Esophageal Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Year Day 1 Yes 2 No signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2X No 25. Was case referred to medical examiner? Hospital or Attending Physician: 26. Place of Death (Check only one) Division of Vital Be Hospital: Other: 1 Tyes 2 X No ဂ 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 24 hours after death.
e Funeral Director: Aft
detely filled in by the fun 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koucetchou, jocelyne 163748 05/30/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou 201 East University Parkway Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State JUN 0 1 2012

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THOMAS STANLE) Month 13:57 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death HOSP SOUTHERN MARYLAND CLINTON PRINCE GERRY If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Director** 03-20-1945 WASHINGTOW, UX or 28a-f show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director TEMPLE HILLS 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a SPRICEWOOD within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian item 27 is marked other than "natural", or ite other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 🗆 Yes 2 📉 No Specify: BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) GOVERNMENT OFFICIAR DOLICE and Mental Hygien Be 17. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maiden Surname) HLBXANDER STANLE OSEPHINE WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Minor WITE 4506 SPENCEULOOD CT TEMPLE HILLS, 40 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 \*\*Cremation 3 A Removal from State RIVERDALIS PARK CRANZRILLY KIVEKOME, 40 4 Donation 5 Other (Specify) Signature of Funeral Service License BB. Robert 874 Upshur STAW DC 2011 BIANCHI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death rotension Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ respiratory acute Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at after death. Director: After 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending iniury work? Accident Suicide Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral Completely filled Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier Doc 64289 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ourrante State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03785 State of Maryland / Department of Health and Mental Hygiene Anastacia Rose Smith 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 18, 2012 0521 hrs **Medical Examiner** ROSE SMITH ANASTACIA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Director CountryMARYLAND 07/03/1990 1 M 2 X F 21 Yrs 217-29-1805 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show PRINCE GEORGE'S BOWIE MARYLAND hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 13704 GULLIVERS TRAIL 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Specify: BLACK 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages i and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "." PRIVATE 2 HAIR STYLIST 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) B ANNETTE TRAYLOR RODERICK SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) 3704 GULLIVERS TRAIL, BOWIE, MARYLAND 20715 RODERICK SMITH / FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State WASHINGTON NTL CEMETERY 5/26/2012 SUITLAND, MARYLAND 4 Donation 5 Other Specify. 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line (Medical Death Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate

UNPENDED

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

				- 13	amine
	xecuted		n and	- transit	cal Ex
760,	icate be e		g physicia	the buria	/Medi
89 xo	eath certif		attending	for use as	siciar
P.O. E	that the d		ned by the	detached	by Ph
ords, l	w requires		is been sig	should be	pleted
Reco	n: The la		tificate ha	or, page 2	Com
f Vita	Physicia		er this cer	ral direct	To Be
Division of Vital Records, P.O. Box 68760,	Attending	death.	ctor: Aft	y the fune	cation
Š	spital or A	ours after	neral Dire	filled in b	Certifi
	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	Tn the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical Certification: To Be Completed by Physician/Medical Examiner

29b. Signature and title of certifier

Carol Allan, MD

Medical

IF FEMALE:	23c. If yes, outcome of preg	nancv				23d. Date	of delivery	
23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3	Ectopic pregn	ancy	Month	Day	Year
1 Yes 2 No 9 ✓ Unknown	4 Pregnant at time of de 9 Unknown	eath 5 Other (Sp	ecify)					
Part II. Other significant conditions c	ontributing to death but not re	esulting in the underlyin	ig cause (	given in Part I.			atribute to the ca	use of death?
					24a. Was an		. Wera autopsy	findings available
					autopsy perform 1  Yes 2	ed? No	prior to comple death? 1 Yes	etion of cause of
25. Was case referred to medical			26.Place	of Death (Check	only one)			
	spital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursi	ng Home 5 Re	esidence 6	Other:	
27. Manner of Death  1	28a. Date of Injury (Month, Day Year) May 18, 2012	28b. Time of Injury 0235 hrs	1	ry at Work? Yes 2. ✓ No	28d. Describe hor Passenger in			n
3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, factor d / Highway	y, office b	ouilding, etc.	28f. Location (Str. or Town, Star Northbound Rou	te)		
29a. Certifier (Check only one)  2 Medical Examiner: 0	: To the best of my knowled							(-)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

May 19, 2012

31. Date filed (Month, Day Yea State Registrar

and manner stated

HALLDUN

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Due to (or as a consequence of):

Due to (or as a consequence of):

AMENDED

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\overset{\mathsf{Month}}{\mathsf{MAY}}$ 2012 EVELYN SIMON 9:44 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours oCT. Day, NORTH CAROLINA **Director** 242-56-0866 75 1936 1 M 2 X F Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown yinjury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 🗆 No MD PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9106 PINEVIEW LANE 20735 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CAFETERIA MANAGER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLAUDE BLUE CORA BEATRICE LEAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIMON/DGT. GWENDOLYN 13007 TRUMBULL DRIVE UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State crematory or other place 1 X Burial 2 Cremation 3 Removal from State PINE GROVE CEMETERY 5/22/2012 JACKSON SPRINGS NC 4 Donation 5 Other (Specify) J.B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final ACLITE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO THE MOCAPET TO TH Onset and Death Physician/ ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Ecqueritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 1 ☐ Yes ∠ E 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital; Other: မ 1 🗌 Yes 2 X No 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and time 29d. Date signed (Month, Day, Year) Wh D18545 MAY 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. WISOTSKY M.D. 12070 OLD LINE CENTRE #207 WALDORF, MARYLAND 20602

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 30° 2012° ar 10:11 AM Bobby Jean Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-44-0198 1 **X** M 2 □ F **Director** Yrs. Feb 24 1945 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 ☐ Yes 2 🙀 No Maryland | Caroline Greensboro 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? items 23a or ner must be n ö Funeral 21639 USA 13070 Ridgely Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S "natural", or item ledical Examiner n 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 \sum No þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: Year or Dates. 65-69 Completed 3 Widowed 4 Divorced Black. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medio once. Water Elementary/Secondary (0-12) College (1-4 or 5+) Queen Anne Co. Supervisor Waste Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Tiller 011y Thomas Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13070 Ridgely Road; Greensboro, Maryland 21639 Sonjia Thomas/ wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Eastern Shore Vet Cm June 11 2012Hurlock, Maryland 4 Donation 5 Other (Specify) 21. Signatur / Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septic disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Dav 4 Pregnant at time of death 9 Unknown signed by the at Id be detached f 2 🗆 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 🗌 Yes 2 📉 No performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital or Attending Physician: 26. Place of Death (Check only one) Vital Be 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/3-/2012 00064120 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Zerhah

31. Date filed (Month

134/2012

10

A

100

2124

DOB

Book

Aay 9733 Health Way Drive Berlin M'D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:10AM Arend Roger Wychgram 05 - 24 -2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 97 Mt. Royal Avenue Harford Aberdeen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours 218-52-2558
Usual Residence of Decedent Director 1**X** XM 2 □ F 62 Yrs 09-02-1949 Maryland 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director be notified 1 Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 23a ( "natural", or items 23 97 Mt. Royal Avenue 21001 USZ 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married XXMarried 1 Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Mercedes Entreprenuer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F 2 Ashby Wychgram Ruby Chamber and 2 should k Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 21001 Mt. Royal Ave., Aberdeen, Md 97 Margaret Wychgram (wife) or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, Stat West Chester 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RA Ferris & Co Inc 05/29/2012 Pennsylvania 22. Name and Address of Facility Zellman Funeral Home 21078 Washington St. Havre deGrace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ METASTADE UROTHELIAL CANCHOJA 7 cmsts Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last physician and stran Due to (or as a consequence of): Physician/Medical certificate be as attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? jo Day Month Year Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 1 Yes 2 No this certificate Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 - No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 28c. Injury at work? 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer Hospital or Attending 1 Natural Pending 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29c. License number // 33088 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

103 31793 WD SUNTA

SECAM MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 18455 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ Judy Darlene Williams 18 2012 Рм 1:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Date of Birth **Funeral** Days (Month, Day, Year) 178-38-7479 Director 1 □ M 2 🎽 F 10/04/1949 PAUsual Residence of Decede 28a-f show 10a. State aţ 10c. City. Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🔀 No MD Frederick Frederick 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a on Medical Examiner must be 5672 Crabapple Dr. 21703 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the laborer Air Pax Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Percy Statler Helen Higgins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau Nathaniel Williams/husbnad 5672 Crabapple Dr., Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 05/23/2012 Frederick, MD 4 Donation 5 Other (Specify) Mt. Olivet 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Aspiration Physician/ Dhlumonia disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) y physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No Yes 2 N 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 No Hospita မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 Yes 2 No Natural 5 Pending after death. Director: Af 2 Accident
3 Suicide
4 Homicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Box 68760 P.O. Records, Division of Vital completely filled in by 24 hours a

May 18, 2012 Frederick MO D62180 of person who completed cause of death (Item 23a) (Type, Print) 400 West MI 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

0

State

29a. Certifier

(Check only one) 29b. Signatur

title of certifie

Day

29

Year

Black, White, etc.

Month

Day

White

10:50A

Maryland

10d. Inside City Limits

1 ☐ Yes 2 No

21639

Year

Birthplace (State or Foreign Country)

2012

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at other than E. Pages 1 and 2 should be transmitted of Health and Mental Frant; if item 27 is marked of other traumatic permit. Pages Department of I Important: If its any injury or o

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

sician and burial-transit attending physician this

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Envoy of Denton Denton Caroline If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 1**X** M 2□F Months 213-22-0325 87 July 9 1924 Usual Residence of Decedent 10c. City. Town or Location 10b. County Director Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14635 Cherry Lane 21660 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pipe fitter US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond C. Williams, Sr. ပ္ Mary Amanda Brackett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14635 Cherry Lane; Ridgely, Maryland 21660 Betty Jane Williams, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation May 30 2012 Stevensville, MD 22. Name and Address of Facility P.O. Box 160; Greensboro, MD 21. Signature of Funeral Service Licenses Steph Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END STAGE RENAL disease or condition resulting in death) Due to (or as a consequence of) ATHROSCUROTIC CARDIONASCULAR DISEACE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 AVENIA HTPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar

JUN 01

ca

DHMH 17 Rev 1/2001

To the Hospital within 24 hours a To the Funeral C

10053094

death (Item 23a) (Type, Print)
321 BLOOMINGDAK AUE FEDERALSBURG MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26<sup>Day</sup> Physician/ May Month 2012ª Patricia Wright 8:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Caroline 12200 B Kibler Road Greensboro Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Davs Min. Nov. OI Hours Y 935 220-28-7140 Director 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔯 No Caroline Greensboro Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12200 B. Kibler Road 21639 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🗓 No by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16h, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Control Elementary/Seconday (0-12) College (1-4 or 5+) 12 animal control officer Caroline Co. Animal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic 6 Robert Hazel Harding George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Wright/ 11598 Water Oak Ct.; Woodbridge, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Hopkins Family Cemet June 1, 2012 Woodbridge, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. Box 160 Greensboro, MD 21. Signature of Juneral Service Licenses Fleegle and Helfenbein Funeral Home, PA 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tulmonary disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ milure tailure 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No

Physician/ Medical Examiner burial-trai

28a-f shov

0

23a

or items

'natural",

within 72 hours after

should be filed within 72 h and Mental Hygiene.

Maryland 21215-0036

Baltimore,

traumatic event, the Medical Examiner

must be notified at

physician s the burial attending p signed by the a d be detached f page 2 s Be မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director.

Certificate:

Medical

that the death certificate be Box 68760

P.O.

Division of Vital Records,

the Hospital or Attending Physician: The law

25. Was case referred to medical examiner? 1 ☐ Yes 2 No	os
27. Manne of Death	I

Accident

Homicide

Suicide

29b. Signature

1103	1 Inpatient	2 🗆	ER/Outpatient	з 🗌 і	D
	28a. Date of injury (Month, Day, Yea		28b. Time of injury		2
n ne				М	L
		28a. Date of injury (Month, Day, Yea	1 ☐ Inpatient 2 ☐  28a. Date of injury (Month, Day, Year)	1  Inpatient 2  ER/Outpatient  28a. Date of injury (Month, Day, Year)  28b. Time of injury	1   Inpatient 2   ER/Outpatient 3   I  28a. Date of injury (Month, Day, Year)   28b. Time of injury  M

AC	Other: 4	☐ Nursing H	ome	Residence	6 Other (Spec
	Injury at work? 1  Yes	2  No	28d.	Describe how inj	ury occurred

ıg H	ome 5 Residence 6 Other (Specify)
	28d. Describe how injury occurred
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certi	fier 1 Cer	tifying Physicia	an: To the best of m
(Che	ck 2 🗌 Me	dical Examiner	: On the basis of exe
only	one) 3 Cer	tifving Nurse F	Practioner: To the h

determined

n: To the best of my knowledge, death occured at the time, date and place, a	and due to the cause(s) and manner as stated.
On the brack of accomplisation and/on increasing the accomplished the second	and the state of the second effects and all the state of the second

26. Place of Death (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation	i, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death or	ccurred at the time, date and place, and due to t	he cause(s) and manner as stated.
and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

			4-1	8		$\rightarrow$	1			~	ب	nve	ر
30.	Name and	address	of per	son v	vho	completed	cause	of de	eath (	Item	23a)	(Type,	Print)

	D	4	7	4	7	2	
							_

			,
May		_	
May	7 (	201	$\Box$

	coffrey	,

mi

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 Cynwood Dr. Easton,

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		artment of H		and Me	ental Hyg	iene	0112	18458
		Reg. No. 2 9 1									10400		
	Physicia Medic		Decedent's Name (First, Middle	Arlene	Waldman	n Weiss				2. Date of Deat Month <b>May</b>	Day 20	2012	3. Time of Death 12:30 a M
	Examin	er	4a. Facility Name (if not institution, give street and number)  4b. City, Town								4c. Co	ounty of Death	
The second	Funeral		Rockville Nursing Home Rockville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.							B. Date of Birth			utgomery  nplace (State or Foreign
	Director		087-16-4074 1 □ M 2 🗓 F   && Yrs.						Min.	(Month, Day,		Cou	ntry)
	d ow t		Usual Residence of Decedent  10a, State 10b, County			y, Town or Lo	-4:		M	arch 14	1,192	4 N	ew York
	ryland I-f sh ied a	cto	,		Toe. City	y, IOWN OF LO		t Cost					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	or 28a notif	Dìre	Maryland Mo  10e. Street and Number	ntgomery			10f. Zip Code	er Spr	ung		Na Citize	n of What Cou	
	with the 23a country the 1st be	eral	3221 South Leis	ure Worle	d Blvd	#1a		2090	06		og. Onizo	u.s	
	tems er mu	Funeral Director	11. Marital Status		edent Ever in U.S		Vas Decedent of Hi Yes, specify Cuba			y Yes or No-	14.	. Race - Amer	
36	ifter d ", ori amin		1 Never Married 2 Man	ried 1 Yes	2 🗶 No		Yes 2X No			san, etc.)	Sn	Black, White	
8	ours a atural	Completed by	3 X Widowed 4 □ Divorced	Year or D									aucasian
15	72 h an "na Medic	mpl	(Specify only highe	st grade completed		(Give I	ent's Usual Occup ind of work done o O NOT use retired)		of working		16b. Kind	of Business/I	ndustry
212	within giene. er tha the l		Elementary/Secondary (0-12)	College (1	-4 or 5+)	Comp	uter Prog	gramme	er		Fede	eral Go	overnment
nd	filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, L	,				18. Mother	er's Name <i>(F</i>	First, Middle, N		,	
yla	uld be Ment narke	J.	-	Herman Wa	ldman					Miriam			
Mar	2 shou th and 7 is n traum		19a. Informant's Name/Relations		) au ab trau	1	g Address (Street a						
é,	and and the tealt tem 2		Cheryl Robin Weiss 20a. Method of Disposition	McGowan - 1		<del></del>	12 Elois ( sition (Name of	. Aven	nue, r			tion - City or T	
o U	age 1 ent of nt: If i		1 ☐ Burial 2 🗶 Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from	State C	emetery, cren	natory or other plac					,	Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Another it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L		MG 102-L	<b>f</b> 22		s of Facility	y S <b>i</b> mp	le Tribu	te Fun	neral &	Cremation Ctr.
			23a. Part 1. Enter the disease, or	complications that	caused the death				· · · · · · · · · · · · · · · · · · ·				Approximate
	testicion/		shock, or heart failure. List of Immediate Cause (Final disease or condition	*		Anton	y Diseas	0					Interval Between Onset and Death
	Medical		resulting in death)		(or as a consequ		.g 0.03 0003						
	Examiner	-	Sequentially list conditions,	b	Myocardi	ial Int	arction						
	g <b>50</b>	Examiner	if any, feating to immediate cause. Enter Underlying Cause (Disease or injury  Atrial, Fibrillation							1			
	xecut	Еха	that initiated events resulting in death) Last Due to (or as a consequence of):										
09	ate be executed ohysician and the burial transit	dical		d	Cerebroi	vasculo	vr Accide	nt					
876	tificate ng phy as th	Med	IF FEMALE:										
9 X	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna Birth 2  Feta	il death 3	Ectopic pregnanc	ÿ			230	d. Date of deliv	
P.O. Box 687	is that the death certifications by the attending rate detached for use as	by Physician/Me	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unk	nant at time of d nown	ieath 5∟	Other (specify)					Month	Day Year
Ö.	hat th ed by detac	y Ph	Part II. Other significant condition	ns contributing to	leath but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
Ś.	ures t sign uld be	q pe								1 □ Ye	s 2 🗆 I	No 3 🗆 Pro	bably 4 💢 Unknown
Orc	w requires s been siç 2 should k	plet								24a. Was ar			opsy findings available ompletion of cause of
Division of Vital Records,	Physician: The law this certificate has al director, page 2	Completed							_	autops perform 1 \square Yes 2	ned?	death?	_
<u> </u>	ertifica ector,	Be (	25. Was case referred to medical examiner?	The same			7	ace of Death	h (Check or		1 22	111-120	
<u> </u>	Physic this or	욘	1 ☐ Yes 2 💢 No 27. Manner of Death		Inpatient 2 🗆			4 A Nur		5 Reside			y)
0 0	ding h. After funer	sate	1 💆 Natural 5 □ Pendin	9	th, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆	≀at ? Yes 2□1		d. Describe ho	w injury oc	ccurred	
Sio	Atten r deat sctor: by the	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho			100 2 1	-	f. Location (Str	eet and N	umber or Rura	al Route Number,
<u>×</u>	tal or s afte al Dire ed in	Ce	4 El Homicide determi	build	ng, etc. (Specify)	)				City or Town,	State)		
	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  Within 4 hours after death.  Completely filled in by the funeral director, page 2 should be detached for use as the buriatings.	Medical	(Check 2 Medical E	Physician: To the bax xaminer: On the bax Nurse Practitioner	sis of examination	and/or invest	igation, in my opinio	n, death occ	curred at the	e time, date and	d place, an	id due to the ca	ause(s) and manner stated.
	withi To the	-	29b. Signature and title of certifier	Mac V.	Poxen	in	29c. License	number <b>D0047</b>	7330	29		igned (Month,	
			30 Name and address of person v	who completed caus	se of death (Item	23a) (Type, P	rint)						
			Thomas Joseph,	M.D., 50	) W. Edm	onston	Drive,	Suite	207,	Kockvi	elle,	Maryl	and 20852
	Stat Registra		31. Date filed (Month, Day, Year) MAY 24 20	112 Seres	legistrar's Signat	par	J.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 20. Witkop Marlene 2012 11:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N. Chevy Chase Montgomery 3807 Montrose Driveway If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 577-92-3728 Director 1 🗆 M 2 😿 F 90 Yrs. 01/09/1922 Germany Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director North Chevy Chase Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 USA 3807 Montrose Driveway 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White If Yes, Give Year or Dates 3 ₺ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) At Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Heinrich Hermann Prinz Margarete Kuhne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or other training. Thomas G. Witkop - Son 8827 McGregor Dr., Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/25/2012 Washington, DC 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signatur Funeral Service Licensee 6160 Oxon Hill Rd., Öxon Hill, MD 20745 Approximate
Interval Between
Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ars Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and-trar ng physician an as the burial-tr Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No ō Month Day Year ed by the a g Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown Completed | 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 K No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

215

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 2 3 2012

DOVO

32. Registrar's Signature

nd

29d. Date signed (Month, Day, Year) 05/21/2012

Davenport.

Nancy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4b. City, County of Death Hospice Hou 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** de (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Director 1 D M 2 C 26 New ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director VA 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral -olmes USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 2 No Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) GOVERNMENT life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ပ Nich olson, JR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Important: If item 27 any injury or other tra niece Method of Disposition 20b. Place of Disposition (Name of 1 🗹 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory renument Mem. 6-4-2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 10 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate et and Death Immediate Cause (Final Physician/ disease or condition 4 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy be detached for Day 5 Other (specify) Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 this certificate has 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital the funeral director, æ 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2010 မ 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 27. Manner 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) atural injury 5 Pending after death. 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie License number se of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Man 2°ear Joanna Lucretia Ina Nelson Williams 3:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Regional Hospital Prince George Laurel Laurel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year)1934 217-75-2283 West Africa Director 78 1 🗆 M 2 🗶 F February 18, Sierra Leone, Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No Prince Georges Beltsville Maryland 10f. Zip Code 10g. Citizen of What Country? West Apr. 102 with. Funeral 20705 10407 - 46th AVenue: Building A; Sierra Leone, Africa death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates. 'natural", 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 2 years Housewife Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked t any injury or other traumair ည Elizabeth Coker Joseph Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4317 Josephine Avenue; Beltsville, Maryland 20705 Olabisi Hanciles (Daughter) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State **Freetown, Sierra** 20b. Place of Disposition (Name of Date 25. cemetery, crematory or other place) June 1 X Burial 2 Cremation 3 Removal from State ingtom Cemetery 2012 4 Donation 5 Other (Specify) Leone,West Africa 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 Sandalf 23a. Part 1. Enter the disease, or complications that can sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ erebrovascular disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner teriosclerotic Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examir the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical that the death certificate be P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No į Dav Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinsons Disease To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 N has page 2 🗌 No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 \sum Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending ours after death.

Neral Director: Ai

filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a
To the Funeral I
completely filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number no 7300 Van Dusen Road 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Laurel, 20707 Burguieres MD Laurel Regional 31. Date filed (Month, Day, Year) 32, Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician/ CHARLES E. ZELL 2012 June Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Darlington 2103 Glen Cove Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 8/3/1980 Hours 199-60-3067 MĎ Director 1 💢 M 2 🗆 F 31 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State Director 1 Yes 2 XNo Harford Darlington MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Harford 21034 Funeral 2103 Glen Cove Road items 23a death 1 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Construction Worker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked of Ruth A. Flaharty George L. Zell, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terri A. Zell/Wife 2103 Glen Cove Road, Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/6/2012 Darlington, MD Darlington Cem. 21. Signature of Frin ral ervice Liv nsee 22. Name and Address of Facility Inc., Delta, 7314 Harkins Funeral Home, orser 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List entry one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death g 🗌 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2; certificate has performed 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ၉ ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Medical Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation s after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Venkata Parsa,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

M.D., 510 Upper Ches.Dr., Ste. 409, BelAir, MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		4	For State of Ma	aryland / Depa Cer	irtment of He tificate of De				0 10160			
		1 Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death										
	Physicia Medic	n/	Sylvina I. Anderson				Month _	Day Year	11:30 PM			
A COLOR	Examin	_	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County of Dealti				
J.			Manor Care Dulaney  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Towso	On If Under 24 Hrs.	8. Date of Birth	9. B	irthplace (State or Foreign			
	Funeral Director	ľ	217-60-0223   1 □ M 2 N F		Months Days	Hours Min.	(Month, Day, Ye	(Month, Day, Year) Country)  March 7, 1924 Jamaica				
			Usual Residence of Decedent	88 Yrs.			March 7,	1724	10d. Inside City Limits			
	yland -f sho ed at	ctor	10a. State 10b. County	10c. City, Town or Loc	timore				1 又 Yes 2 □ No			
	r 28a notifi		Maryland N/A  10e. Street and Number	Dal	10f. Zip Code		10g	. Citizen of What C				
	23a c		516 Richwood Avenue		212	212		USA				
	items	Funeral	11 Marital Status 12 Was Decedent E	ver in U.S.	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.			
36	after c	d by	1 Never Married 2 Married 3 Widowed 4 XDivorced  Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No 1	☐ Yes 2 X No			Specify: B	lack			
21215-0036	e fied within 72 hours after death with the Maryland hat Hygiene.  do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education	16a. Deced	lent's Usual Occupat	tion	16	b. Kind of Busines	ss/Industry			
215	in 72 e. han "r	ᇣ	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5	life. Di	O NOT use retired)		ng	Solf F	mployed			
	ed within Hygiene. <b>other tha</b> ent, the N	look	17. Father's Name (First, Middle, Last)	Hous	se Keeping		e (First, Middle, Mai		mployed			
Maryland	oe filed antal Hy ked oth c event	10 E	John Mitchell				e Collins	,				
ary	1 and 2 should be file f Health and Mental H item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street ar	nd Number or Rura	l Route Number, Ci	ty or Town, State,	Zip Code)			
	and 2 sl Health a tem 27 i	] [	Margaret Arnold, Grand daught		Richwood A							
ore	ge 1 ar nt of He : If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	natory or other place	)		c. Location - City	, Maryland			
Baltimore,	: Pa tmer tant jury		4 Donation 5 Other (Specify)	Metro Cr	ematory In							
Ba	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee Thomas G	regor 2	remation 99 Freder	Society ick Road	Ot Maryla Baltimor	nd, Inc. e, Mary1	and 21228			
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between			
berta	Physician/		Immediate Cause (Final disease or condition	c Obstr	uctive ;	Pulmor	vary de	seure	Onset and Death			
man of	Medical Examiner		resulting in death)  Due to (or as	a consequence of):	boart	Carl	1 ne					
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of):	11							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	e.  C Obstr a consequence of: a consequence of: a L Fib	rillate	on						
	e exection and an aurial-tr	al Ex	resulting in death) Last	a consequence of):  rtensic								
092	cate be executed physician and s the burial-transit	edical	d	1 (01)								
189	certific nding use as	n/M	IF FEMALE: 23c. If yes, outcome	of pregnancy 2  Fetal death 3	Tectonic pregnancy	N/		23d. Date of				
Box 687	death e atte	sicia	in the past 12 months?  1 ☐ Yes 2 ☑ No 4 ☐ Pregnant a		Other (specify)	,		Month	Day Year			
P.O.	requires that the death certific. been signed by the attending F should be detached for use as	Completed by Physician/M	9 Unknown  Part II. Other significant conditions contributing to death	out not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute	e to the cause of death?			
σ,	res the signed	d by	Take in Called Significant				1 🔀 Yes	2 🗆 No 3 🗆	Probably 4 🗆 Unknown			
ord	been should	lete					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of			
ec	ne law te has age 2	l m					perform	ed? death	n? Yes 2 ∰ANo			
alF	ian: T irtifica ctor, p	Be C	25. Was case referred to medical examiner?			ace of Death (Chec						
Ξ	Physic this ce al dire	은		ient 2 ER/Outpatie		4 LX Nursing H	ome 5 Residen		pecify)			
n o	ding F th. After funer	cate	1 Natural 5 Pending (Month, Day 2 Accident Investigation		work'		Zou. Describe non	injury coounica				
Division of Vital Records,	Atten ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,			
Div	tal or irs afte al Dira led in		building, e						a stated			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of 2 Medical Examiner: On the bast of 3 Certifying Nurse Practitioner: To the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	avamination and/or invo	etigation in my oninic	on death occurred :	at the time, date and	place, and due to	the cause(s) and marrier stated.			
	o the vithin to the comple	Σ	only one) 3 ☐ Certifying Nurse Practitioner: To t 29b. Signature and title of certifier	ne best of my knowledge	29c. License	number	29	d. Date signed (M	onth, Day, Year)			
à	- > - 0		I Andlo	0.	H00.	5442	7	6-8-	12			
	5V		30. Name and address of person who completed cause of CYrus Asadi 1012 Fa	death (Item 23a) (Type,	Print) May	Lutte	rneli	MD.	onth, Day, Year) 12 21093			
	Sta	ate	31 Date filed (Month, Day, Year) 32 Regist	rar's Signature								
	Sta Regist		1111 1 2 2012 . Parent	AGUA								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 50 AM Physician/ SHIRLEY EVELYN APPOLD 2012 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Baltimore Square 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** Min. 213-32-9198 75 Director 1 □ M 2 🖾 F 9-18-1936 MARYLAND 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 X No NOTTINGHAM MD. BALTO. 10g. Citizen of What Country? 10e. Street and Number ò Examiner must be Funeral 23a USA 3812 PERRYHURST PLACE 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian Black White, etc. , 0 þ 1 Never Married 2 Married WHITE 1 Yes 2 No Specify If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) LEGAL SECRETARY LAW OFFICE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ MILDRED V. WISEMAN RUSSELL G. DEVOE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1349 ARTISTS LANE BEL AIR, MD. 21015 DAVE APPOLD SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-13-2012 TIMONIUM, MD DULANEY VALLEY 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. 21. Signatu of Ineral Service Dicenses NOTTINGHAM, MD 9705 BELAIR ROAD sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a Part /. Enter the disease, or complications that caused shock, or heart failure. List only one cau on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ neumoni Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami ncutopeni and burial-tra Due to (or as a consequence of): ding physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate beneare browns after death.
• Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 **N** No Hospital: ျ 1 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 \( \sum \text{Yes} 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28d. Describe how injury occurred injury ✓ Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one)

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rankl

Square deive Baltimore MD21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30, per DVR, g928 6-12-12 sm. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ June Mary Louise Ange 20Î2 9:10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 301 Bigley Ave. Lansdowne Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 1, Year 1928 Days Hours Min. 1 M 2 X F 199-20-3044 84 Yrs Pennsylvania **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c, City, Town or Location the Medical Examiner must be notified at rector 1 Yes XX No Maryland Baltimore Lansdowne ā 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 301 Bigley Ave. 21227 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Xidowed 4 □ Divorced Completed 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security/ and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nicholas Andrasy Margaret Adamus permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic t traumatic 19a. Informant's Name/Relationship (*Type, Print*) Brian Ange/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5713 Mineral Ave., Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Lake View Mem. Grds. June 12,2012 Sykesville, Maryland 22. Name and Address AMBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pulmonary Physician hubertension one year disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a monsequence of) burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Atrial fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 \(\sum\_\) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum\_\) Other (Specify) 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Baltimore, Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After I completed filled in by the funeral purers. Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif D25575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore, MD, 21201 Susan Wolfsthal 31. Date filed (Month, Day, Year) 32. Registrar's Si State JUN 1 2 2012

Registrar

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

8 June 2012

State Registrar

5

Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 1 2 2012

V. Pramanik

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vedatneyel Pramanik MBBS, Sinai

32. Registrar's Signature

RES-000

Hospital of

29d. Date signed (Month, Day, Year)

12\_

Baltimore4215

6

Baltimoru

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 911 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 M North Carolina **Director** 75 sidence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Maryland Baltimore Middle River 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 62 Honeycomb Road 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Yes Give Specify. Specify: 3 Midowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Grady Evans Ethel Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael John Brady (Son) 62 Honeycomb Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2X Cremation 3 □ Removal from State Bayview Crematory 06/12/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature Francisco Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 1407 Old Eastern Avenue, 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been shown that the death of the funeral Director. Cause (Disease or hinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year sate has been signed by the a page 2 should be detached a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check curred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death of 29b. Signature and title of certification D0069314 06/09

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of parson who compression

31. Date filed (Month

JUN 1 2 2012

Moods

Waltham

RMaulle MD 21234

who completed cause of death (Item 23a) (Type, Print)

istrar's signature

8813

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Physician/ BRILEY JULIUS 0251AM JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death THEJOHNS HOPKINS HOSPITAL BALTIMORE C If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth 11-6-1945 **Director** 237-72-3008 1 🕅 M 2 🗆 F NC 66 28a-f show "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director n/a Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2602 McElderry Street 21205 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Yes 2 X No Yes, Give þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo Specify. Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Blast Furance Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o မ Mayo Briley Helen Daniels and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Maxine P. Briley/Wife 2602 McElderry Street, Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Gardens of Faith 6-15-2012 Rosedale, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Paltimore Co. of Funeral Service Lice 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician. Hemoptysis disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Day Pregnant at time of death been signed by the a should be detached f Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending injury Accident Investigation 1 Tes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Nutherna Shaw MD RES-000 JUNE 08 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 ORLEANS ST BALTIMORE MD 21287 Katherine Shaw MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

JUN 1 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia R. Brittingham 100 Medical 3012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TENINSULA KEGIONAL Medical 3A6156414 HICOMICO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. Director 219-22-3649 1 □ M 2 X F Jan 2, 1928 Usual Residence of Decedent Maryland fshov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Somerset 1 ☐ Yes 2√ No Princess Anne 10e. Street and Number ŏ 10g. Citizen of What Country? Funeral items 23a 11974 Edgehill Terrace Road 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ŏ Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other ti any injury or other traumatic event, the once. housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Tilghman Holiday Gussie Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Gordon/daughter 30380 Maple Street #206 Princess Anne, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🔲 Cremation 3 🔲 Removal from State 4 X Donation 5 D 4 ther (Specify) Signature of Furery Service Licensee Nay 1 ... Nay 1 ... State Affaton Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cerebro vas cular Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of perform 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certifics filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 🔏 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) |요 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury ☐ Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by determined City or Town, State) 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

100 E

D68222

021

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 20a-c, 22 per fligg28 6-20-12 sm
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State Of Ivial ylan	•	tificate of I		-	Reg. No. 20	2 18470			
	Physici		1. Decedent's Name (First, Middle, Last)	Bren	7			2. Date of De		3. Time of Death			
at the last	Medi Exami		4a. Facility Name (if not institution, give str		7	4b. City, Town, o	r Location of Deat	h Way	2S 201				
			Future Care Pinev		-	Clin			Prince George's				
	Funeral Director		5. Social Security Number 223-30-1629  Usual Residence of Decedent	7. Age (In yrs. le		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird Aug 16		Birthplace (State or Foreign Country) rginia			
	land show dat	ţō	10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits			
	e Mary r 28a-i notifie	Director		George's C	linton				1 ☐ Yes 2 😾 No				
	with the s 23a or ust be	Funeral C	10e. Street and Number   9106 Pine View Lar	ne		10f. Zip Code 20	735		10g. Citizen of What Country? USA				
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates.	If	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🗓 No	Black, Wh	4. Race - American Indian, Black, White, etc. Specify: black					
5-0	72 hou "natu edica	Completed	15. Decedent's Educ (Specify only highest grade			ent's Usual Occup ind of work done of		rking	16b. Kind of Busines	s Industry			
212	vithin i piene. er than the M		Elementary/Seconday (0-12)	transport	ation								
nd	filed via Hyg	To Be	17. Father's Name (First, Middle, Last)		ř		Maiden Surname)	acton					
r <u>y</u> la	d Men marke	-	Henry Brent	D.(1)				tie V. B					
, Ma	nd 2 sho ealth an m 27 is ner trau		19a. Informant's Name/Relationship (Type, Brenda Blue/daught	ier	19b. Mailing 2414	g Address (Street a Hillfor	and Number or Ru d Drive	ral Route Numbel Burlingt	; City or Town, State, 2 on, NC 27	Zip Code) 217			
Baltimore, Maryland 21215-0036	age 1 al ent of H nt: If itel y or oth		20a. Method of Disposition  1 ☐ Burial 2 <b>S</b> Cremation 3 ☐ Re 4 ☐ Donation 5 <del>② Other (Specify)</del>	moval from State C6	emetery, crem	ition (Name of atory or other plac		Date	20c. Location - City o	•			
alti	permit. F Departm Importar any injur		21 Si verti of Funeral Service Moor	<del>in state</del> Atl: de, Director					Glen Burni Cremation				
ш	6 2 7 2 9		Dennyllile		Jr B	homas A	lien P.A.	201090 R	idge RD. H	and Funeral anover,MD 2107			
<b>~</b> .[	Physician/		23a. Palk 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ause on each line.	1	the mode of dying		or respiratory arr	est,	Approximate Interval Between Onset and Death			
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):								
1000	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence oi):								
	ificate be executed ig physician and as the burial-transit		Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):								
8760	ate be on the property of the pure	<b>Nedical</b>	<b>L</b> d	_									
687	ertifica Iding p se as t		IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome of pregnan	ICV								
J. Box	v requires that the death certific been signed by the attending p should be detached for use as	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 acts of the seath 5 acts	Ectopic pregnanc Other (specify)			23d. Date of de Month	elivery Day Year			
is, P.O.	uires that in signed uld be det	by	Part II. Other significant conditions contril Coronary Arter	, 1		derlying cause giv	en in Part I.		bacco use contribute t es 2 □ No 3 □ F	o the cause of death?			
Vital Records,	e law rec has bee ge 2 sho	Completed						24a. Was a	sy prior to	utopsy findings available completion of cause of			
E I	sician: The law is certificate has b irector, page 2 sl	Ф	25. Was case referred to medical		_	26 Pla	ace of Death (Chec	perfor	2 No 1 Ye	es 2 🗆 No			
<b>X</b>	hysici his cer I direc	To B	examiner? 1  Yes 2 No Hosp	1 🗌 Inpatient 2 🗌 E	R/Outpatient	Otho	P		ence 6 Other (Spe	cify)			
10 UC	nding Path. r: After te funera	icate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🔲	at		w injury occurred				
DIVISION	al or Atte s after dea Il Director	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  28a. Date of injury 28b. Time of injury at work? 1 Yes 2 No 28b. Time of injury at work? 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred											
- /	In othe Hospital or Attanding Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be												
	with to the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company o		29b. Signature and title of certifier		3 , 15	29c. License	number		9d. Date signed (Mont	th, Day, Year)			
		-	30. Name and address of person who comp	leted cause of death (Item 2	?3a) (Type, Prir	nt)	63337		May 27	2012			
			Dorty Secry m	7.835	Smith	n Avenu	e Stez	es Bal	trave Mcl	21709			
	Stat Registra	~	JUN 1 2 2012	37. Registrar's Signatu	par	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#16a, b, 18-20c, 22perff, 6928, 6/14/2012, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 40 PM Physician/ Month 2012 Mary E. Blackwell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balti Franklin Square Hospita
5. Social Security Number 16. Sex 77. Age (In yr more osedale If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 218-44-0572 **Director** 1 🗆 M 2 🛛 F Yrs 1944 Mar 17, Usual Residence of Decedent 68 or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be n 21237 Funeral USA 6600 Rossville Blvd er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 ☐ Divorced unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 11 Private Housekeeper Be unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last) ဂ္ traumatic Agnes Bradley Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2003 Magnolia Woods Ct. Apt F Edgewood, MD 21040

6401 YORK Road Baltimore, MD 19a. Informant's Name/Relationship (Type, Print)

Hilberta McMullen-sister
Nathan Prouty/social worker Department of Health ar Important: If item 27 is any injury or other trat once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 M Other (Specify) in state 6-14-2012 Metro Crematory Catonsville, Maryland nall re of Funeral Service Licenson @3 Name and Address of Facility and 65 Parker Funeral Home PA Baltimore, MD 21201 Baltimore Street Director Frederick Ave. Balt.MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Pu disease or condition resulting in death) a Massive monacy Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No certificate To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred Certificate: injury 1 Natural 5  $\square$  Pending s after death. 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a
To the Funeral C
completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 78 Kes 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore 31. Date filed (Month Chuna 9000 Franklin Saince Drive h, Day, Year)

DHMH 17 Rev 06-2011

Registrar

State

egistrar's Signature

2

JUN 1

12-03913		Please Type								gible.	
Dominique Beau	-	State 1- For State	e of Maryland		irtment d <i>tificate</i> d		and ivid	ental H	ygiene	20	12 1847
Dhuriaia		Registrar 1. Decedent's Name (First, Middle,Li	ast)	Cer	incate C	Dealli			2. Date of Dea	eg. No.	3. Time of Death
Physicia Medical Exami		Dominique B							Month May 22, 2	Day Year	2322 hrs
		4a. Fecility Name (if not institution, g	ive street and number	)		4b. City, Tov	vn, or Locati	on of Death		4c. County of D	eath
		S/B Route 5 North of Kirl	oy Road			Clinton				Prince Geo	orge's
Funeral				ge (in yrs. ia	ast birthday)	If Under		Inder 24Hrs	_		. Birthplace (State or oreign
Director	Į		M 2 F		55 Yı		Days	ours will	FEb 15	<b>,</b> 1957 W	ashwhgton DC
any		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Loca	ation					10d. Inside City Limits
≥ 1											1 Yes 2 No
Maryland 28a-f show d at once.	용	DC 10e. Street and Number		<u> </u>	Washi	10f. Zip Co	ode		Country?		
he Ma 1 or 28	Director	723 Varnum Stree	et NW						unk 1	USA	
with t		11. Marital Status	12. Was Deceden						pecify Yes or No		merican Indian, Black,
death	Funeral	1 Never Married 2 Marrie	Armed Forces	No	lf	Yes, specify (	Juban, Mexi	can, Puerto	Rican, etc.)	White, e	tc.
after	Đ		lf Yes, Give Year or Dates:	_		Yes 2					black
hours fratur		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade cor College (1-4 or			nt's Usual Oc nost of workin				16b. Kind of Busine	ess/Industry
36 nin 72 E.	음	tierneritary/secondary (0-12)		3+)				1		chur	a h
d with	Completed	17. Father's Name (First, Middle, Las	<u>O</u>		ma	intena				Maiden Surname)	<u></u>
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be (	Ludovic Deaug	e					Clel	ie Dume	ck	
21 Should I hould I Mer is man ritie even		19a. Informant's Name/Relationship				•				nber, City or Town, S	
MD and 2 sho alth and 27 is		Michelle Beauge/	daughter	20h B		School sition (Name			Gaithe	rsburg, M.	
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 Burial 2 Cremation 3	Removal from St		rematory or o		or corretery,	'	Date	200. Location - Cit	y or Town, State
tim t. Pag tment rtant:		4 Donation 5 X Other Specia	y in state		Loo	N d A d	J	-11/4			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatie event, the Medical Examiner must be notified at once.		21. Sig. ture of Funeral Tyce-Lice	Wade Dir	ector						I. Baltimo	ore Street
Physician	-	23a. Pan I. Enter the disease, or con		the death.	Do not enter	altimo the mode of d	lying, such a	as cardiac o	or respiratory arro	est, shock, or heart	Approximate Interval
Medical		failure. List only one cause on a Immediate Cause (Final disease	each line. <sub>a.</sub> Multiple Injuries								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cons		):						
	اي	Sequentially list conditions,	Due to (or as a cons	ocuence of	١.						
	틢	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a corrs	equence on	). 						
ed ssit	Examiner	events resulting in death) Last	Due to (or as a cons	equence of	):						
executed an and al - transit	<u>8</u>	UNPENDED	AMENDED								
		IF FEMALE:	23c. If yes, outcome	me of progr	anov					23d. Date of deli	iven
1876 rtifical ing ph	hysician/Medi	23b. Was decedent pregnant in the past 12 months?	1 Live birth	ne or pregn		etal death	3 Ecto	opic pregna	ancy	Month	Day Year
OX 6 ath ce	Sicia	1 Yes 2 No 9 Unknow	Pregnant at	time of dea	ath 5 C	ther (Specify	)			1	
the de	Phy	Part II. Other significant conditions	9 Unknown	h but not re	sulting in the	underlying ca	use given in	Part I.	23e. Did to	bacco use contribute	e to the cause of death?
, P.O. Box 68760, irrs that the death certificate be execut signed by the attending physician and be detached for use as the burial - trail.	É		,				<b>3</b>				Probably 4 Unknown
ds, equire equire ould b	eted							24a. Was a		e autopsy findings available	
Cords,	Completed									med? deat	
tal Rec		25. Was case referred to medical				26.	Place of Dea	ath (Check	1 ✓ Yes	2 No 1 🗸	Yes 2 No
Vita hysician this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpatien					Residence 6 🗸 0	ther: Scene
ling Ph	+	27. Manner of Death	28a. Date of Inju	iry (ear)	28b. Time of	Injury 28c	. Injury at W		28d. Describe h	now injury occurred struck by auto	
ion itendi leath.	atio	1  Natural 5 Pending Pending 2 ✓ Accident Investigation Azy 22, 2012 2316 hrs 1 Yes 2 ✓ No								struck by auto	
Divisior pital or Atteuc	Certification:	3 Suicide 6 Could no	t be 28e. Place of Ir			et, factory, of	fice building	ı, etc.	or Town, S	tate)	r Rural Route Number, City
									lorth of Kirby Roa		
To the Hos within 24 h To the Fuc completely	Medical	(Check only	clan: To the best of m er:On the basis of exa								
To To Com	Med	29b. Signature and title of certifier	and manner stated.			29c. Li	cense numb	per		29d. Date signed	(Month, Day, Year)
		Sand Durk	lell mi			c	C.M.E.			May 23, 2012	
_	-	30. Name and address of person who	completed cause of c	leath (Item	23a)						
		Pamela E. Southall, MD	Assistant Med	,		0 W. Baltir	more Stre	eet, Balti	more, MD 2	1223	
		31. Date filed (Month, Day, Year)  JUN 1 2 2	012 32. Begistra	r's Signatur	1. ba	. 4.1				-	
Regist	rar	JUN I 2 2	VIL Chave	N B	i. Ala	V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Ellicott City Health & Rehab Ctr Ellicott City If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Oct 17, 1950 1 🕅 M 2 🗆 F Months Kansas 212-56-6900 Director 61 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 x Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 1207 Valleybrook Court #J USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Yes, Give black Completed 3 Wildowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 iment of Health and Mental Hygiene tant: If item 27 is marked other than jury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) file clerk SSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Willie Butler Vera Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9060 Gracious End Court #103 Columbia, MD Vera Garner/mother 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation in state 22 Name and Address of Facility
State Anatomy Board
21201 21. Signature of Fundal Pervice Mensee Nay 655 W. Baltimore Street 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition Medical resulting in death) Due to (or as a con **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L. Fetal uson
Pregnant at time of death
Unknown 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Yes 2 No signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe death? 2 No this certificate 1 🗆 Yes 25. Was case referred to dical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred Certificate: After injury work? 5 Pending efter death.

Director: Aft
d in by the fur 2 🗌 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [ 3 [ 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ June . 2012 Albert Ensor Baublitz 9:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1209 W. Northern Parkway Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours June 26,1916 Mary Land 212-09-4069 95 1 **№** M 2 🗆 F Director Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ed other then "netural", or items 23e or 28a-f sho event, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland Director 1XX Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21209 1209 W. Northern Parkway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 43—146 Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify. 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Master Plumber Plumbing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental F permit. Page 1 and 2 should be fi Department of Health end Mental Importent: If item 27 is marked eny injury or other traumetic ev ones. Pege 1 and 2 should be Joseph Elvin Mattie Ensor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Newcomer/ Daughter 1209 W. Northern Parkway, Baltimore, Maryland 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Line Cemetery June 14,2012 Baltimore Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burgee Henss SEitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of the ettending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospitel or Attending Physician: The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by eral Director: Affer this certificate has been signifiled in by the funeral director, page 2 should be 2 No Division of Vital Records, 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 20 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funel completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. rson who completed cause of death (Item 23a) (Type, Print) m 1 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 June 9:10 A M Jacquelyn Sawyer Burge Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 18110 Bilney Drive Olney Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 312-26-0329 1 □ M 2 🕅 F Yrs 1928 83 Oct 3. Maine Usual Residence of Deceden 28a-f show aţ 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 1 Tes 2 X No Olnev MD Montgomery 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n 0 10e, Street and Number Funeral 18110 Bilney Drive 20832 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian, Examiner Armed Force Black, White, etc. 0, þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: "natural" 3 X Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Software Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 700. မ Gordon G. Reillv Bertha Evelvn Sawver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 18110 Bilney Drive Olney, MD 20832 Burge / Son Arthur 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 6/11/2012 4 Donation 5 Other (Specify) Woodbine, Maryland Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 years Uterus Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): resulting in death) Last Acquecgn Physician/Medical P.O. Box 68760 attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a Medical

10 V

Dog.

URGE

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier (Check

29b. Signature and title of certifier

Leon Hwang,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

1396 Piccard Dr. Rockville, MD 20850

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D45880

29d. Date signed (Month, Day, Year)

June 8, 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last 2 Date of Death 3. Time of Death Physician/ Month unp Medical llity Name (if not institution, give street 4b. City, Town, or Location of Death and number **Examiner** County of Death If Under 24 Birthplace (State or Foreign Country)
 CT Age (In vrs. last birthday) 8. Date of Birth Hrs. **Funeral** Months Days Hours Min Oct. 3, 1 M 2 046-18-2565 89 CT**Director** Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Carroll Taneytown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 113 Butterfly Drive 21787 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify "natural", 3 XWidowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Sales Clerk Clothing Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lester Siemon Grace Quirk traumatic Department of Heath and Important: If item 27 is r. any injury or other traumany injury or other traumane. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Butterfly Dr., Taneytown, MD 21787 Mr. Richard Berner (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 X Removal from State Bernard's Cemetery6/14/2012 New Haven, CT 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 100764 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ျာ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural injury 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🕅 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 10 2012 AM June 2:30 Alice E. Burdette Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carrol1 Lorien Nursing & Rehabilitation cente Airy 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months 215-18-1716 1 □ M 2 🛣 F Director 93 July 15, 1918 MD Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b County within 72 hours after death with the Maryland Director Examiner must be notified 1 🗌 Yes 2 🕻 No Sykesville MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a Funeral 21784 USA 5611 Old Washington Rd 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates Completed 3 XWidowed 4 ☐ Divorced Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Belle Cross Frederick Brosenne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3860 Henry James Dr. Westminster MD 21157 Carlton L. Burdette (Son) 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 6/13/2012 4 ☐ Donation 5 ☐ Other (Specify) View Cemetery Marriottsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lice HAIGHT FUNERAL HOME & CHAPEL PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and attending physician a I for use as the burial-Physician/Medical The law requires that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death by the Unknown Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed?

1 Yes 2 No certificate 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be SSISIENLIN examiner? 2 **M** No Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury work?
1 Yes 2 No Natural 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office determined

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this Certificate: 2 Accident
3 Suicide
4 Homicide filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify) Medical 29a. Certifier 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fay B. Boskent Ma Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** County of Death Regional Prince Hospital Laure George's 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Davs Hours (Month, Day, Year) 287-34-8702 **Director** 1 □ M 2 🛣 F Feb 11, 1941 West Virginia or 28a-f show 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 V No Prince George's Laure1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12100 Dove Circle 20708 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify. marked other than "natural", Specify Completed 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) medical supplies purchasing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kinslow Parris Ossie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9600 Milestone Way #3004 College Park, MD 20740 <u>Celeste Bosken</u>t/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Sign to n Funeral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street //Director Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ POXIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events neumonid attending physician and for use as the burial-trar resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Multiple Sclerosis 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Ventral 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo ပ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, in 24 hours after death.

the Funeral Director: After this pletely filled in by the funeral of 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 7300 Van Dusen Road

State Registrar

Laurel Regional

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee-Llacer, MD

31. Date filed (Month, Day, Year)

## 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARY, BROWN 3RD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 228-30-1613 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show Baltimore Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a or Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ö 1 ☐ Yes 2 No ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Mental Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health sem 27 i L. Brown -Arkanasa Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5 1 Burial 2 Cremation 3 Removal from State Important: any injury o 4 Donation 5 ☐ Other (Specify) 21/Signature of Funeral Service Licenses ter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failing. List only one cause on each line. Immediate ause (Final DISSEMINATED **Physician** disease of condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine PACEMAKER INFECTION Due to (or as a consequence of) Physician/Medical SYNDROME SINUS IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ of Vital Records, KIDNEY FAILURE, THROMBOCYTOPENIA 1 ☐ Yes Completed DEMENTIA, PULMONARY EMBOLISM 24a. Was an VENOUS THROMBOSIS DEEP 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Division 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours

and manner stated.

WAQAS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Washington, DC NW 20011
Date 20c. Location - City or Town, State 20c. Location - City or Town, State 6/11/2012 Baltimore, MD 1101 E. North Ave. Baltimore, MD 21202 Approximate Interval Between Onset and Death INTRAVASCULAR COAGULATION DAYS PAYS WEEKS 7 YEARS 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) D0072498 JUNE 3RD 2012 4940 Eastern Avenue, Baltimore, MD, 21224

0420 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 ☐ No

MIKWIT

2012

USA

Specify:

14. Race - American Indian,

Black

State Registrar

Medical

(check only one)

MUHAMMAD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 2

MD

as Patricia Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G930, 8/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:30 PM Physician/ 2012 Patricia Clark 10 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore piler n/a If Under 1 Year If Under 24 His 344<sup>2</sup>26 6348 <del>433 26 6348</del> 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours **Director** 1 □ M 2 💢 F March 21,1928 Arkansas 84 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 ☐ Yes 2 X No 28a-f Maryland Baltimore Towson 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ö must be r 23a Funeral 21204 USA Smelton Place, Apt#1206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian ? is marked other than "natural", or ite traumatic event, the Medical Examiner Armed Forces? Black White etc. 1 X Never Married 2 - Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Bayview College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Microbiologist Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ C.C. Clark lunknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 8820 Walther Blvd.Apt#3220 Parkville, Maryland 21234 LaVerne Nimmo guardian 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 06/11/2012 Baltimore, Maryland Signature of Fundral Service Licensee Stephanie Custer | 22. Name and Address of Facilit Cremation Society of Maryland, Inc. nance 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tran a consequence of physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the use as attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No ģ Day Month Year Pregnant at time of death 4 Pregnant : 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an page 2 autopsy 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify, 2 🗆 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural Accider injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certify 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	5	State of	Marylar		rtment of F		and M		21	112	18481	
			Registrar  1. Decedent's Name (First, M.	fiddle, Last)			Cer	inicate of L	Jeaur	I	2. Date of Dea	Reg. No. 👇 👇	) have	3. Time of Death	
Phys	siciar edica		Ira Donald	Crowe							May 26	, 2012	Year	9:10 PM M	
	mine		a. Facility Name (if not instituted as Gilchrist			r)		4b. City, Town, or Towso		of Death			y of Death L <b>timo</b> 1		
Fune Direc			Social Security Number 214-64-5558		7. 1 2 🗆 F		last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Day Aug 3,	v, Year)	place (State or Foreign ntry) y land		
and	i i	o	Usual Residence of Deceder 10a. State 10b. Co	_				10d. Inside City Limits							
Maryla 28a-f		irect	MD Ba	1timore				owson						1 ☐ Yes 2 🔀 No	
with the	nat be n	Funeral Director	10e. Street and Number  305 E. Joppa Road #1004  10f. Zip Code 21286											ntry?	
partition (e), Interpretation Z I Z 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1  Never Married 2  Married 1  Yes, specify Cub.  1  Yes 2 No  If Yes, Give  Year or Dates.										cify Yes or No- Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc.  Specify: white		
hin 72 hours after ne. than "natural", o	le Medical	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of E													
ed with	em, m	an F	12 17. Father's Name (First, Mid	dle. Last)	0		Lat	orer	18. Mothe	er's Name	(First. Middle.	fact Maiden Surnan	ory v	work	
Tarro	IIC eve	卢	Marshall								eeman				
d 2 should salth and N	er trauma		19a. Informant's Name/Relate Shirley Ric					g Address (Street a					State, Zip 21280		
Dalumore, Dermit. Page 1 and Department of Hee mportant: If item	no oc om		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 💢 Donation 5 🔁 Otl		noval from St		Place of Dispo cemetery, crem	sition (Name of eatory or other plac	ce)	D	late	20c. Location	- City or T	own, State	
permit. Departr	any inj		21. Signature of Fin Sen	V Na	y for	5	22 1	Name and Addres tate Ana altimore	ss of Facilit tomy MD	<sup>ነ</sup> ይየ <del>2</del> ፕ	d 655 W	. Balt	imore	Street	
Physici Medi	ical		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	se, or complicat List only one ca	use ón each	ised the dea line. as a conseq	tatec	r the mode of dyin		cardiac o	r respiratory arr	rest,		Approximate Interval Between Onset and Death	
Exami		۱ ی	Sequentially list conditions,	b											
po d	1	m	if any, leading to immediate Cause (Disease or injury	4	Due to (or	as a conseq	uence of):						- 4		
ate be executed physician and the burial-transit	מורומ	dical Examiner	that initiated events resulting in death) Last	C	Due to (or	as a conseq	juence of):								
te be on the horizontal she but the bu		dica		d.											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and commissive fined in the theory charactory has 2 second the relationship for use as the purish-transit.	200000000000000000000000000000000000000	<b>→</b> I	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		If yes, outco 1  Live Bir 4  Pregna 9  Unknov	th 2 🗔 Fet nt at time of	al death 3	Ectopic pregnand Other (specify)	су			1	ate of deliv	very Day Year	
Lires that the signed by	חם ספ מפומ	þ	Part II. Other significant co	nditions contrib	outing to dea	th but not re	sulting in the u	nderlying cause giv	ven in Part	l.				the cause of death?	
The law requires ate has been signance 2 should be	Dage 2 3  DG	Completed									24a. Was autop perfo 1  Yes	osy ormed?	Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of	
VICAL  iysician: is certific	ion,	m	25. Was case referred to med examiner? 1 ☐ Yes 2 ☐ Yo	dical	oital:			Oth	lace of Dea er:					11.0	
OI V  ig Phys ter this	<u>a</u>	e: 10	27. Manner of Death		28a. Date of	injury	ER/Outpatier 28b. Time of	t 3 🗆 DOA   28c. Injur	4 ∐ Nu yat			dence 6 Dot low injury occur		in Haspice	
ending ath. or: Afte	5	licat	2 Accident In	ending vestigation	(Month,	Day, Year)	injury	M 1 □	<br Yes 2 ☐	No No					
tal or Attendir rs after death.	ed iii by	al Certificate:		could not be etermined		Injury - At h , etc. <i>(Specit</i>		et, factory, office			28f. Location (S City or Tow		ber or Rura	al Route Number,	
the Hospi nin 24 hou the Funer	ipietery iii	Medical	(Check 2 ☐ <b>Med</b> ionly one) 3 ☐ <b>Cert</b> i	ical Examiner: ifying Nurse Pr	On the basis	of examination	on and/or invest	ccurred at the time igation, in my opinion death occurred at t	on, death o	ccurred at	the time, date a	nd place, and d	ue to the ca	ause(s) and manner stated.	
To t To t	3		29b. Signature and title of ce	ertifier			MD	29c. Licenso	e number	0		29d. Date sign	ed (Month,	Day, Year)	
			30. Name and address of pe	rson who comp	leted cause	of death (Iter	m 23a) (Type, F		u Te	41	05	BALTI	MORE	z MD	
	State istra	7	31. Date filed (Month, Day, Ye	<sup>ear)</sup> 1 2 2012		l <del>st</del> rar's Signa	ature .	ale							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Physician/ Month May 24 8:55 AMM Lawrence Cohen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 130 Hearne Road #1113 Annapolis Anne Arundel 5. Social Security Number UNK 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreig **Funeral** unk 1 XM 2 □ F **Director** Oct 18, 1947 Usual Residence of Decede 64 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d Inside City Limits Director items 23a or 28a-f s ner must be notified 1 Yes 2 No Annapolis MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21401 130 Hearne Road #1113 unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. unk Black, White, etc. 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. er than "natural", the Medical Exa Specify Completed 3 Widowed 4 Divorced unk 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. ပ unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corp Gillian/AACo Police DEpt 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Signature of Fun 1 ervice Line 2 Aniel A State Anatomy Board 655 W. Baltimore Street Nay 21201 Raltimore, MD 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death MUDCARCIAL Infarction Ph, sician/ disease or condition ציינית Medical resulting in death) Due to (or as a consequence of): Examiner ROVI Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events שעה לני נטו מס מ ניטווספ the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforn death? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after death | Director: / within 24 hours a

27. Manner of Death 1. Natural 2 Accident	5 Pending Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No		how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify		tory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
(Check 2.	Medical Examiner	r: On the basis of examinatio	n and/or investigation	, in my opinion, death occurr	red at the time, date	cause(s) and manner as stated. e and place, and due to the cause(s) and manner stated office Couse(s) and mainer as stated					
29b. Signature a o i	tle of contilior	> no)		29c. License number 7 00 36 78	-6	29d. Date signed (Month, Day, Year) 6 - 1 - 1 2					

Roesler pord, Clen Burnie, RD 20060

State Registrar

Medical

31. Date filed (Month, Day, Year,

KATZI M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-03691 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Cawthern State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 14, 2012 1338 hrs **Medical Examiner** Robert Cawthern 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3516 O'Donnell Street 5. Social Security Numberunk 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign CountryMaryland Months Davs Hours Director 1 X M 2 F 59 Oct 22, 1952 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 X Yes 2 No Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3516 O'Donnell Street USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. Never Married 2 X No Yes 1 Yes 2 No specify: If Yes, Give Year 4 X Divorced white 2 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 accounting financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ George Cawthern Agnes Cain 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M James Cawthern/brother 3002 dunglow Road Baltimore MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State more, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 X Other Specify: in state 22. Name and Address of Facility 21. Signature of Funeral Service Licensee State Anatomy Board Baltimore, MD 21201 Naylor Dani W. Baltimore Street er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and faiture. List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transit The law requires that the death certificate be executed ca **AMENDED** UNPENDED Physician/Medi of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus page 2 should be Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✔ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes ၉ 28a. Date of Injury (Month, Day, Yea 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No 2 \_\_\_ Accident Investigation

To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifi filled in by

28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 15, 2012

30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18484 State of Maryland / Department of Health and Mental Hygien 👂 🦳 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year June June 6, Kathleen Jacqueline Cubbage 1:38 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-58-2978 Director 1 □ M 2🗓 F 60 July 14, 1951 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 X Yes 2 ☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 123 Courtland Place 21014 USA or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working WBBAGE, Kathleen Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Computer Programmer Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Francis Rafter Margaret Patricia German and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 John Cubbage / Husband 123 Courtland Place, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or oonce. 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn. 6/12/2012 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death

MONTH Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician sthe burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 No 9 Unknown months? Pregnant at time of death Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons perforn Yes 1 L Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 Mo 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gerhifying Nurse Practitioners To the best of my know 29b. Signat 29d. Date signed (Month. Day, Year) D0056296 6-6-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive BelAir MO 2/0/4 10 V 31. Date filed (Month, Day, Year) State Registrar

202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EOPOLI CURTIS June June 8:00 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Capitol Heights Prince George's 7006 Valley Park Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number Age (In yrs. last birthday) Days (Month, Day, Year) Director 423-38-2852 1 🛣 M 2 🗆 F Oct 14, 1931 Alabama Usual Residence of Decedent 80 fshow or 28a-f shoven 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 XNo Prince George's Capitol Heights MD 10e. Street and Number 10g. Citizen of What Country? 9 er than "natural", or items 23a of the Medical Examiner must be Funeral United States 7006 Valley Park Road 20743 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc by 1 Never Married 2 K Married X Yes African Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed American Year or Dates. 1958-63 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Retail Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Susie Wilcox Rushton Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 Valley Park Rd. Capitol Heights, MD 20743 Marie R. Curtis / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 6/13/2012 Woodbine, Maryland 4 Donation 5 Other (Specify) Journey Crematory Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Signature of Funeral Service Li 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown the g Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 No Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 24 hours after death.

Funeral Director: After this certificate etely filled in by the funeral director, pag 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 2 🛛 No 0 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, June 11, 2012 D23743

State Registrar 7525 Greenway Center Dr. Greenbelt, MD 20770

30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)

Martin Weltz

31. Date filed (Month, Day, Year)

12-04329

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

isa Ann Carro.	ll.		rtment of Health and Mental I ificate of Death	Hygiene Reg. N	2012 1848							
Physic Medical Exam		Decedent's Name (First, Middle,Last)	1	Date of Death     Month Day	3. Time of Death							
Wieurcal Exam	·	Lisa Ann Lonegro Carrol  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	June 8, 2012	4c. County of Death							
		103 Belfast Road	Lutherville Timonium		Baltimore County							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 213-88-7468 1 M 2 X F 5		Irs. 8. Date of Birth (MI in. Dec. 4,	M/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)							
aoy		Usual Residence of Decedent  10a. State 10b. County 10c. City. T	own or Location		10d. Inside City Limits							
	L	MD Baltimore	Timonium		1 Yes 2 No							
arylan 8a-f si at 00	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?							
the M 3a or 2	Į į	103 Belfast Road	21093		USA							
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene, 'f is marked other thato "natural", or items 23a or 28s-f sho ratic eveot, the Medical Examiner must be outlified at occe.	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puer		14. Race - American Indian, Black, White, etc.							
rs after ural",	ו≳	3 Widowed 4 Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify:  16a. Decedent's Usual Occupation (Give kind o	fund does Itch	Specify: White Kind of Business/Industry							
2 hour	sted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re		Kind of Business/Industry							
21215-0036 21215-0036 suld be filed within 7 Mental Hygiene. marked other thao	Completed	12		Insurance								
15-0 iled w Hygie d othe	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17b. Father's Name (First, Middle, Last)  18b. Kind of Busing the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of											
121 Id be f Aental	Frank Lonegro  Beverly Jean Brown  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S											
AD 2 2 shou 1 and 1 27 is n	Po National State   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   12340   Rosslare   Ridge   Road   #103   Tim.   12340   Rosslare   Roa											
G, N I and Health Fitem												
MOF Pages ent of int: If												
lalti rmit. epartm sports jury o		21. Signature of Juneral Service Licensee	22. Name and Address of Facility Lemmon Funeral Ho									
	To We Iddon't Road IImon'tum, In											
Physician Medical			Between Onset and									
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive At  Due to (or as a consequence of):	herosclerotic Cardiov	ascular Dis	sease Death							
		Sequentially list conditions, b.										
	ıminer	if any, leading to immediate Due to (or as a consequence of):			A							
d sit	Exan	(Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):										
<b>0,</b> the executed sician and burial - transit	S E	w UNPENDED AMENDED 23a, pt.II	27 par ma c028 6-15-	12 cm								
50, te be ex nysician burial	fedical	X UNPENDED AMENDED 23a, pt. II, 27, per me, g928 6-15-12 sm  23d. Date of delivery										
Box 6876( ne death certificate the attending phy.	an/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregr		Month Day Year							
OX (eath ce	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)									
ision of Vital Records, P.O. Box 68760, Attrodiog Physiciao: The law requires that the death certificate be executed refearth. Tedearth. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	Phy		ulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?							
ires that the signed by	d b	Obesity		1 Yes 2	✓ No 3 Probably 4 Unknown							
Division of Vital Records, in or Atteodiog Physiciae: The law requirable and death death.  In pirector, After this certificate has been seled in by the funeral director, page 2 should I	Completed			24a. Was an autopsy	24b. Were autopsy findings available pnor to completion of cause of							
Reco	E			performed?	death?							
Vital Rec ysicino: The his certificate director, page	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check									
Physic rathis	P	1 Yes 2 No			ence 6 Other: Scene							
n of odiog Pl h. : After e funera	<u>ë</u>	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe how inj	jury occurred							
isior Atteorer death	Certification:	2 Accident Investigation	e, farm, street, factory, office building, etc.	28f. Location (Street a	and Number or Rural Route Number, City							
Div ital or ral Div	The real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the real and the r											
See. Place of Injury - At home, farm, street, factory, office building, etc.  286. Location (Street and Number of or Town, State)  299. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as and manner stated.												
To the within To the compl	Medical	and manner stated.										
	≊∣	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)							
0		20 Normand address of 2	O.C.M.E.	Jur	ne 9, 2012							
OGME		<ol> <li>Name and address of person who completed cause of death (Item 23 Mary G. Ripple MD. Deputy Chief Medical Examin</li> </ol>	·	more, MD 21223								
St	ate	31. Date filed (Month (Month) 32. Registrar's Signature		,								
Regis		4411 6 4 6016 Brane	- freel									
DHMH 17 Rev 1/2	001		ORIGINAL									

## Baltimore, Maryland 21215-0036

			For State Registrar		State of N	Marylar	nd / Depa <i>Cei</i>	artmen <i>tificate</i>	t of H	lealth Death	and M	lental Hy	/giene	2012	18	487	
ı	Physicia		1. Decedent's Name (First, i	John	,	ncis	Can	ning			_	2. Date of D Month June		2012 Year	3. Time o		
100	Medic Examir		4a. Facility Name (if not insti				oun	1	Town, or	Location	of Death	Julie					
-	Exami		10809 N	antuc	ket Terra	ice		- ,,		otom			4c. County of Death  Montgomery				
	Funeral	г	5. Social Security Number	6. Se	7. Age (In yrs. last birthday)			If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	f Birth 9. Birthplace (State or Foreign				
	Director		058-20-5898	1	<b>X</b> M 2 □ F	85	Yrs.	Months	Days	Hours	Min.	September 1	ay, Year) er 26, 1	1926 <sup>C</sup> I	vew Yor	k	
	wo ow	1.	Usual Residence of Decede 10a, State 10b, C			1.0											
	yland f sh ed a	턍	Toa. State	burity		10c. Ch	ty, Town or Lo	cation							10d. Inside C	,	
	Mar 28a	ire		lontg	omery					toma	С					s 2 X No	
	th the	<b>Funeral Director</b>	10e. Street and Number					10f. Zip					10g. Citiz	zen of What Co	ountry?		
	ms 2 mus	lue		antuc	ket Terra		0 140.1	No. Book		0854	*.:-0.(0	'' M		nited S			
	r dea or ite	Į,	<ul><li>11. Marital Status</li><li>1 \( \sum \) Never Married 2 \( \sum \)</li></ul>	?		Yes, speci	fy Cubar	spanic Ori n, Mexicai	n, Puerto	cify Yes or No Rican, etc.)	-   1	<ol> <li>Race - Ame Black, Whit</li> </ol>					
336	al", c	g p	3 ☐ Widowed 4 ☐ Div		1 X Yes 2 I If Yes, Give Year or Dates.		1055	☐ Yes 2	X No	Specify.	*		. 5	Specify:	hite		
21215-0036	hours natur ical I	Completed by		cedent's E	ducation	1940-1	16a. Deced	lent's Usual	l Occupa	ation			16b Kir	nd of Business			
215	i. an "r	ם	(Specify only Elementary/Seconday (0		ade completed)  College (1-4 o	r E . \		kind of world NOT use		uring mos	t of worki	ng	TOD: TO	id of Eddiness	maastry		
212	within giene er th	ပိ	Elementary/Seconday (o	12)	1	r 5+)	Real	Esta	te D	evel	.oper		1 1	Real Es	tate		
pu	filed al Hy d oth vent	Be c	17. Father's Name (First, Mid	idle, Last)			-			18. Moth	er's Name	e (First, Middle	, Maiden S	Gurname)			
/lai	d be Menta arkec	은	Fr	ancis	John Car	ning						Flore	nce S	kahan			
Maryland	19a. Informant's Name/Relationship (Type, Print)							g Address	(Street a	nd Numbe	er or Rura	l Route Numb	er, City or 1	Town, State, Zij	code)		
	nd 2 salth n 27		Jean E. Ca	nning	/ Wife		10809	Nan	tuck	et T	errac	e, Pot	omac,	, Maryl	and 208	354	
ore	of Heriter		20a. Method of Disposition 1 ☐ Burial 2 🗓 Crem	ation 2	Domoual from Sta	20b. F	Place of Dispo	sition (Nam	e of her place	e)	[	Date	20c. Loc	cation - City or	Town, State		
Ĕ	Page ant: l		4 Donation 5 O			ite	Mont Cremat	gomer orium	. Ir	ic.	June	10,2012	Beth	nesda,	Marvlar	nd	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Ser	vice Licens	ee ·		帮	obert 2	Addres	nphre	y Fune	eral Home	e/Bethe	esda-Chev 71and 208	y Chase		
	Physician/		23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final disease or condition		ne cause on each i			r the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approxima Interval Be Onset and 1 Year	tween	
	Medical Examiner		resulting in death)		a. Due to (or a												
	Examine	<u>_</u>	Sequentially list conditions.		b. ———												
	ъ ≓	nin	if any, leading to immediate cause. Enter Underlying	2	Due to (or a	s a consequ	uence of):										
16	ate be executed ohysician and the burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events	1	C. — Due to (or o												
1/2	e exe	<u>a</u>	resulting in death) Last	ı	Due to (or a	s a consequ	uence oi).										
09,	ate b	ğ			d												
687	artific ding p	Physician/Me	IF FEMALE:		23c. If yes, outcom	e of preans	ancy										
Вох	ath ca attena for us	cian	23b. Was decedent pregnan in the past 12 months?		1 Live Birth	n 2 🗌 Feta	al death 3	Ectopic p		/			2	3d. Date of de Month		Year	
Ď.	the shed	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9 Unknow		deall 3 L	other (spe	3011y)						,		
P.0	ad by detac	P	Part II. Other significant co	nditions co	ontributing to death	but not res	sulting in the u	nderlying ca	ause give	en in Part	1.	23e. Did	tobacco us	se contribute to	the cause of c	death?	
S, I	sign d be	q p										1 🗆	Yes 2 2	No 3□P	robably 4 🗌	Unknown	
Records,	requ been shoul	Completed by										24a. Was	an	24h. Were au	topsy findings	available	
ecc	e law thas ge 2 s	Ę.										auto	psy ormed?	prior to death?	completion of	cause of	
m	n: The ficate nr, pay		25. Was case referred to me	leait					00 FI			1 Yes	2 <b>X</b> ) No	1 🗆 Yes	2 🗆 No		
of Vital	siciar certif recto	Be c	examiner?	-	Hospital:				Other	r·		only one)					
<b>&gt;</b>	Phys this ral di	2	27. Manner of Death		1 ☐ Inpa 28a. Date of in		ER/Outpatier 28b. Time of		A Injury	4 ∐ N		me 5 🗶 Resi 28d. Describe		Other (Spec	ify)		
n	ding th. After fune	cate		ending vestigation	(Month, E	ay, Year)	injury	M	work?		- 1	zod. Describe	now injury	occurred			
Sio	Atten dear ctor: y the	Certificate:	3 Suicide 6 0	ould not be		niury - At ho	ome, farm, stre			.00		28f Location /	Street and	Number or Ru	ral Route Numi	her	
Division	after after Dire	Ce	4 L Homiciae a	etermined	building, e	etc. (Specify	1)	, , ,			]	City or To		real field of Field	a route ruin	Jul,	
	spita nours neral	ical	29a. Certifier 1 X Cert	ifying Phys	sician: To the best	of my know	ledge, death o	ccured at t	he time,	date and	place, and	d due to the ca	ause(s) and	I manner as sta	ited.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (	(Check 2 L Med	ical Exami	ner: On the basis of se Practioner: To the	examination	n and/or invest	igation, in m	ry opinior	n, death or	ccurred at	the time, date	and place, a	and due to the	cause(s) and ma	anner stated.	
	To th withir To th comp		29b. Signature and title of co		4		,		License		prido			signed (Month			
			1 Krist	[ S_	Thom	adr	S		D321	156			Ju	ne 8, 2	2012		
	145		30. Name and address of pe	rson who c	completed cause of	death (Item	23a) (Type, P										
	D,		Kristin S.	Thoma:				ico A	venu	ie, N	W #3	42, Was	hingt	on, D.C	. 20016-	-3623	
	Sta Registra		31. Date filed (Month, Day, Y	ear)			ture		-								
			THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE P	/													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16a per th g928 6-12-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Crocket :46 EMOGENE 201 TUNE Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. Month, Day, Year, **Director** 1 □ M 2 🕡 Mar Vland 28a-f show 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10b. County 10d. Inside City Limits **Funeral Director** 1 ☑ Yes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Co. Euclid 23a 4213 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten I Examiner n 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1ac 1 ☐ Yes 2 ☐ No Specify. 3 ₩ Widowed 4 Divorced "natural" Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file dment of Health and Mental rtant: If item 27 is marked o n and Mental 2 Herr Klawe illian SIMMO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -daystter Sanara Wal Baltimore rad other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 PBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease An roximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition METASTATIC CANCER Physician LUNG MUNTHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): and Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performe 2 No Yes 2 No 1 🗌 Yes Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death ivision of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled i by determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. Sicense number 0005/865 2 Ish Certs JUNE 10, 2012 -57-AGNES HUSPIME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS, MD 900 CATON CHARLES BALTIMORE 31. Date filed (Month, Day, Year) 32. Fintrar's Signature State Registrar DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea									II Copie		_	ible.		
		For State Registrar		31	iale of N	naryian		tificate			and iv	1ental Hy	Glei Reg. I	20	12	18489	
Physicia	n/	1. Decedent's Nam	e (First, Middle	, Last)								2. Date of De Month	ath		Year	3. Time of Death	
Medic	al	Martha	Foch		ennis			I				June	8,		)	1:30 AM	
Examin	er	4a. Facility Name (if	anklin			pt 41	4		Town, or SEX	Location				4c. County	of Death	ore	
Funeral Director		5. Social Security No. 169 12 95		6. Sex			ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year		9. Birth	place (State or Foreign htry)	
		Usual Residence	of Decedent	I L IVI	2 <b>.A</b> .F		95 Yrs.					08/06/	191	16		nsylvania	
aryland a-f sho fied at	ctor	10a. State  Maryland	10b. County	moro		10c. City	y, Town or Lo	cation								10d. Inside City Limits  1 Yes 2 No	
the Ma or 28% e notif	Dire	10e. Street and Nur	<u> </u>	more		<u> </u>	Essex	10f, Zip	Code				10g.	Citizen of V	Vhat Cour		
h with ns 23a nust b	Funeral Director	1000 Fra	nklin						1221			nited	Sta	tes			
or iten	by Fu	<ul><li>11. Marital Status</li><li>1 Never Marr</li></ul>	ied 2 ☐ Man	A	Vas Decedent Ever in U.S.  med Forces?  ☐ Yes 2 🛣 No  13. Was Decedent of Hispanic Origin? (Specify Yes or Normed Forces?  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							cify Yes or No- Rican, etc.)			e - Americ k, White,	can Indian, etc.	
urs afte ural", il Exan	ted b	3 ☑ Wildowed 4 □ Divorced If Yes, Give Year or Dates. 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedants Education 15 Decedents													wh	white	
72 hou n "nat Nedica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business													usiness/In	dustry	
within giene.		Elementary/Second 12		C	ollege (1-4 or	5+)		enogr	,	r				Areo	-Spa	ce	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (i <b>Abrah</b>	First, Middle, L nam Els	wort h	Focht			7,024-5	es <del>-T</del> ania		er's Name Vera	(First, Middle, <b>Lois</b>	Maide <b>Mi</b>	erley	2)		
d 2 should saith and N		19a. Informant's Na  James R.			int) (son)							Route Numbe				Code)	
Page 1 an nent of He int: If item ry or othe		20a. Method of Disp 1 XX urial 2 4 Donation	☐ Cremation		val from Stat	e c	lace of Dispo emetery, crem	natory or of	ther place			Date 2/2012		Location -		own, State aryland	
permit. Departm Importa any inju		21. Signature of Fu					22	. Name and	d Addres	s of Facili	ty Br		ski	Fune	ral 1	Home PA	
201		23a. Part 1. Enter t	he disease, or	complicatio	ns that cause	ed the death								A MAI	yraik	Approximate	
Physician/		Immediate Cause ( disease or conditio	Final	a	Cm	aust	ure 1	hear	1/10	adu	и					Interval Between Onset and Death	
Medical Examiner		resulting in death)			Due to (or as	aconsequ	ence of):	u Hu	V		-00-				0	Jean	
ad	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying	ь. —	Due to (or as	a consequ	encelof):									/	
executed ian and urial-transit	Еха	that initiated events resulting in death) I	S	c	Due to (or as	a consequ	ence of):								-		
ate be only sicis	dica	d															
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	months?	1 4	yes, outcome Live Birth Pregnant Unknown	2 Feta at time of d	I death 3	Ectopic p Other (sp		4				23d. Dat	e of deliventh	ery Day Year	
at the ed by th detach		9 Unknown Part II. Other signif			-		ulting in the u	nderlying c	ause give	en in Part	l,	23e. Did to	obacco	o use contr	ibute to th	ne cause of death?	
requires the been signed should be	ted by											1 🗆	Yes	2 110	3 🗌 Prol	bably 4 🗆 Unknown	
ne law rei e has be age 2 shi	Completed												osy rmed?	?	rior to co leath?	psy findings available mpletion of cause of	
<b>ding Physician:</b> The law h. After this certificate has funeral director, page 2	Be C	25. Was case referre	ed to medical						26. Pla	ce of Dea	th (Check		2	10 1	☐ Yes	2 L No	
Physic this ce al dire	ဍ	1 🗌 Yes 2 🗓	₽No	Hospit	1 🗌 Inpa		ER/Outpatien			4 ∐ Nt		me 5 A Resid				')	
tending Fleath.  or: After the funer	Certificate:	27. Manner of Death  1  Natural  2  Accident  3  Suicide	5 ☐ Pendin Investig 6 ☐ Could	g gation	Ba. Date of inj (Month, Da		28b. Time of injury	M 28	3c. Injury work?			28d. Describe h	ow inj	ury occurre	ed		
ital or At irs after o ral Direct lled in by		4  Homicide	determ	ined 28	building, e	tc. (Specify)						City or Tow	n, Sta	ite)		Route Number,	
the Hosp in 24 hou the Funer inpletely fi	Medical	(Check 2 only one)	Medical E	xaminer: Or	n the basis of	examination	and/or invest	igation, in n	ny opinior	n, death or	ccurred at	nd due to the ca the time, date a ce, and due to t	ind pla	ce, and due	to the car	use(s) and manner stated.	
To t To 1		29b. Signature and	ille of certifier	ULA	Ms			29c.	License	number	<i>‡</i>		29d. [	ate signed	(Month, I	Day, Year)	
3√		30. Mame and addre	ess of person v	who complete	ted cause of	death (Item	23a) (Type, P	222	. 1	777	RE	USPER	5 /7	NWN	Rd	21208	
Stat Registra		31. Date filed (Month	h, Day, Year) 2012	Reven	32. Regist	rar's Stanat	Ked			/			, ,	•			
				-	7												

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear Ulrike Daughton 7:36 AM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL KURNIE GLEN ANNE HRUNDEL curity Number unk If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Min. Director 1 □ M 2 🔯 F 59 june 26, 1952 10a. State 10b. County with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel MD 1 ☐ Yes 2 🛣 No Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7943 Brockridge Road 20794 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) marked o ဂ္ Page 1 and 2 should be and is m 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 301 Hospital Drive Glen Burnie, MD Baltimore, MD 21201 Baltimore Washington Med Ctr 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 6 □ Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility State Anatomy Board 21201 655 W. Baltimore St. Baltomore, Md. P.11 1. Enter the lisease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HUNC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 5014 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) appen eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: ] 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Confirm Nurse Practitioner: To the best of my low whole and the time date and place, and due to the cause(s) and manner stated confirm Nurse Practitioner: To the best of my low whole and the time date and place, and due to the cause(s) and manner stated confirm Nurse Practitioner: To the best of my low whole and the time date and place, and due to the cause(s) and manner stated confirm Nurse Practitioner: To the best of my low whole and the time date and place, and due to the cause(s) and manner stated confirm Nurse Practitioner: To the best of my low whole and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINON

State

Registrar

31. Date filed (Mo

ULRIKE

DAUGHTON

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 281, per PHYS, G928, 6/12/2012, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Elizabeth L. Dayhoff June 10. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carrol1 1 Year If Under 24 Hrs. Birthplac Country) MD Social Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Min (Month.  $19, \frac{Day, Y}{1}$ 219-14-9158 Dec. **Director** 1 🗆 M 2 🗓 F 87 1924 Yrs Usual Residence of Decedent works 10a, State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 ☐ Yes 2 🗓 No Howard Lisbon 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a PO Box 33 21765 USA or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🗶 No Specify: White "natural", Specify Completed 3 ★ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerical Secretary event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve မ Harvey Munshaur Gertrude Lease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sandra J. Winkles (Daughter) 4451 Arthur Shipley Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) other place) Taylorsville Cemetery 6/14/2012 Taylorsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service License PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phytician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner 10 wars HE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months? Month Pregnant at time of death 1 L Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has perfor 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of Certificate: 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury 28c. Injury at ccurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) WHAT WINDS ALLS Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature an 29d. Date signed (Month, Day, Year, 2 30/Name and address of per ho completed cause of death (Item 23a) (Type, DV WESTMIN STER JUN 1 2 2012 32. Registrar's Signature State Registrar

23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes Assis led 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

9:00 A

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

201

1 Yes 2X No

MD

White

State Registrar

30. Name and address of person who completed cause

DHMH 17 Rev 06-2011

10

of death (Item 23a) (Type, Print)

32. Registrar's Signature

015.

Registrar

Maryland 21215-0036

Box 68760

Division of Vital Records,

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Burt I. Feldman, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number D23958

3305 N. Leisure World Blvd, Silver Spring, Maryland 20906

June 7, 2012

			,	Please	State of							_		_	ile.	
		•	For State Registrar		State of	iviai yiai i		tificate			aria ivi	Citairiy	Reg. N	201	2	18494
	Physicia Medic		1. Decedent's Name (First, Patricia Lyn		,							2. Date of De	ath	av Ye		Time of Death
~~	Examin		4a. Facility Name (if not inst	_				4b. City,		Location o			40	c. County of		
No.	Francis		FRANKLIN S 5. Social Security Number	16.5		Age (In yrs. Ia	ast birthday)	If Under		If Under		8. Date of Bir	ate of Birth 9. Birthplace (State or i			
6	Funeral Director		214-78-1478 Usual Residence of Deced	_	□ M 2 <b>X</b> F	50	* *	Months	Days	Hours	Min.	(Month, Da 07/26/	iy, Yea <i>r)</i> 1961	1	Country) arylar	
	laryland 8a-f shov iffied at	ector	10a. State 10b. C Maryland Ba	ounty ltimo	re		y, Town or Lo									Inside City Limits 1 □ Yes 2 🛣No
	rith the N 23a or 28 st be not	Funeral Director	10e. Street and Number 33 Transverse	e Vive	ກາງວ			10f. Zip		220				itizen of Wha		
7	ems 2	nue	11. Marital Status	C AVC	12. Was Decede		S. 13. 1	Nas Deced			gin? (Spec	cify Yes or No- Rican, etc.)		14. Race -		ndian,
ci A 036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	þ	1 Never Married 2 3 Widowed 4 MDiv		Armed Force 1 Yes 2 If Yes, Give Year or Date	XNo		f Yes, spec				Rican, etc.)		Black, \ Specify:	White, etc.  White	9
Patrici 1	2 hour	Completed		ecedent's E y highest gi	Education rade completed)		(Give	dent's Usua kind of wor	k done d		t of workin	ng	16b.	Kind of Busin	ness/Industr	ry
2 5 T 2 1 2 1 2 1	ithin 7 ene. r than	Com	Elementary/Secondary (	0-12)	College (1-4	or 5+)		o <i>notus</i> e e's A	,					Jursin	a Home	2
	filed al Hy d oth	To Be	17. Father's Name (First, Mi William Dri				11020	<u> </u>			er's Name	(First, Middle,	Maiden		-, 1101	
19€€ Maryland	2 should be th and Ment 27 is marke traumatic		19a. Informant's Name/Rel Bill Duty (Bo	. ,			-	-				Route Number				
$\mathcal{E}$ לוית Baltimore, N	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition  1  Burial 2  Cren	nation 3 [	Removal from St	tate c	Place of Dispo emetery, crei	osition (Nam matory or o	ne of ther place	е)	D	ate	20c. l	_ocation - Cit	ty or Town,	State
$\mathcal{E}$	permit. Pa Departmer Important any injury once.		4 Donation 5 C	Other (Spec	ify)	Bay						08/201 Funera				aryland_
	82 = 89	(			i al al a			1407	ота	<u> Easte</u>	ern A	venue,	ESS	sex, M	arytai	nd 21221
governing.	Physician/		23a. Part 1. Enter the diseashock of heart failure Immediate Cause (Final disease or condition	ase, or con e. List only (		osed the death line.		er the mode	eor dying	g, such as	cardiac or	respiratory at	rest,		Inte	proximate erval Between set and Death
	Medical Examiner		esulting in death)	ſ	_	as a consequ		Fa	ilu	ire						
	ed	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	e d	b. Due to (or	as a consequ	uence of)									
	e e) ciar ouris	a	that initiated events resulting in death) Last	ı	c. Due to (or	as a consequ	uence of):									
1760	icate by physics the t	ledic	2		d											
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the 1	Physician/Medio	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 Yes 2 No 9 Unknown		23c. If yes, outco 1  Live Bi 4  Pregna 9  Unknow	rth 2 ☐ Feta int at time of c	I death 3	Ectopic p	oregnanc ecify)	у				23d. Date of Month	-	Year
, P.O	es that th signed by	by	Part II. Other significant co	onditions	contributing to dea	th but not res	ulting in the u	underlying o	ause giv	en in Part	I.					ause of death?
cords	aw requir as been s 2 should	Completed										24a, Was	an psy	24b. Wer	re autopsy f	findings available ation of cause of
Bec	The la	Con										perf	ormed?		th? Yes 2	] No
ital	certifician:	Be	25. Was case referred to me examiner?  1  Yes 2 No	edical	Hospital:	•			Lou	ace of Dea	· ·			. 🗖		
of V	g Physer this neral di	e: To	27. Manner of Death		28a. Date of	patient 2  injury Day, Year)	28b. Time o injury		8c. Injury work	4 L.I Nt		ne 5 🗌 Resi 8d. Describe			Specify)	
ion	tending leath. tor: Aft the fur	Certificate:	2 Accident	Pending Investigation Could not	on he			М	1 🗆	Yes 2 🗆						
Divis	tal or Ati irs after c al Direct led in by			determined	28e. Place of	f Injury - At ho , etc. <i>(Specif</i> y	ome, farm, str	eet, factory	r, office		1	28f. Location ( City or To			or Rural Rou	ite Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Me	dical Exan	ysician: To the bes niner: On the basis rse Practitioner: T	of examination	n and/or inves	tigation, in a	ny opinio	n, death or	ccurred at	the time, date	and plac	e, and due to	the cause(s	s) and manner stated. d.
	To the within to the complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex c		29b. Signature and title of o		Man	12	//	29c	. License	number			29d. D.	ate signed (A	Month, Day,	Year)
	3		30. Name and address of p				, , , , ,	Print)								
	-		DRTahir MI	E h M	ood 90	000 F	RANKI	in S	ila	rei	OR G	palto	Mo	1212	37	
	Stat Registra		31. Date filed (Month, Day, JUN 1 2 201	2 /	32. Hec	istrar's Signa	ture									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day INDA 2017 June 10 5:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Hospice House Easton Caroline If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 234-74-0044 1 M 2 TXF 64 Yrs. July 19,1947 West Virginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Caroline 1 Yes 2 TNo Preston 10f. Zip Code 10g. Citizen of What Country? Funeral 22913 Dover Bridge Road 21655 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify. White 3 Widowed 4 T Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetologist Cosmetology traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba flie and Mantai I မ Delbert J. Huey Marceline Roukevenia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Heaith a itam 27 i Alan Luceti / Son 22913 Dover Bridge Rd., Preston, Maryland 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date parmit. Page 1
Dapartment of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. <u>06/11/2012</u> | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic non-small all lung Physician disease or condition Mohtf Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ig physician and as the burial-transit Hospital or Attanding Physician: The law requires that the death cartificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attanding p IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by tha a 9 Unknown s baan signed to should ba det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Drunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s cartificata has t diractor, paga 2 s 1 Yes 2 KNo 1 Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 238 No Other: 4 Nursing Home 5 Residence 6 Stother (Specify) 1 Yes ၉ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jakshim 2012 057 June 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKSHMI NAIDYANATHAN 219 S.WASHINGTON ST, EASTON 2 1601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 2 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MOGE Physician/ Sally Ebersberger Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Wilomic 15 Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months 213-34-8320 75 **Director** 1 □ M 2 🏻 F July 23, 1936 Maryland 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? Funeral 21811 USA 67 Wood Duck Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 XNo þ Yes 1 ☐ Yes 2 X No Specify. Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) housewife own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles Conrad Decker Paulina Thelma Minor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 John M. Ebersberger/spouse <u>67 Wood Duck Drive</u> Berlin MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final OVARIAN Physician/ MALIANANT CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquertiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin E4 hours after death.

To the Funcar Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burnar law of the state of the page 2 should be detached for use as the burnary. P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 ET No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Other (Specify) Tor 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 🗂 Natural Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 8400 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

amPleases Type or Printing Black Indeligle Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1508 James M. Eby Tune Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death SAL1341/4 HICIMICO MODIEN CINTE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Country Director 212-22-3057 1 1 X M 2 □ F Jan 16, 1927 Maryland 85 27 is marked other then "natural", or items 23e or 28e-1 show treumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 USA 610 Oyster Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 A Married 1 X Yes 2 ☐ No If Yes, Give δ Maryland 21215-0036 1 Yes 2 No Specify white should be filed within 72 hours aft and Mental Hyglene. Is marked other then "natural", 3 Widowed 4 Divorced Year or Dates. 44-48 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 0 repairman x-ray machines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Franklin Eby Alice Lorretta Brennan 1 and 2 should be of Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Eby/spouse 610 Oyster Lane Ocean City, MD or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 K Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Light see 22. Name and Address of Facility Danje State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Septicenua Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of): resulting in death) Last signed by the attending physician I be detached for use as the burla To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DMI Infection 1 - Yes 2 - No 13 - Probably 4 - Unknown Kozet Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No မှ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29d. Date signed (Month, Day, Year) 06/04 death (Item 23a) (Type, Print) 100 E. CARROLL ST; SALISBURY, MD 21801 USMAN ZULFIDAK, 31. Date filed (Month, Day, Year) State ack Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

20 | 2 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ June 10:45 PM Alberta Eakin Ellison Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Spencerville 16429 Batson Road If Under 24 Hrs 9. Birthplace (State or Foreign If Under 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min (Month, Day, Year) Director 174-22-3444 1 □ M 2 🖾 F Pennsylvania Dec 16, 1924 87 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location at Director be notified 1 Yes 2 X No Burke Fairfax VA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a with Funeral **Examiner must** United States 22015 6002 Mardale Lane , or items and 2 should be filed within 72 hours after death Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 2 **X** No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced White Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate 12 Property Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Roxy White Paul Seymore Eakin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Alberta Ellison / Daughter</u> 6002 Mardale Ln. Burke, VA 22015 item 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date permit. Page 1 s Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 6/12/2012 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signation of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death -Physician/ Gastrointestinal Hemorrhage (Spontaneous) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER and that initiated events Due to (or as a consequence of): resulting in death) Last burial physiciar Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year ģ Month Dav Pregnant at time of death 2 XNo the 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed After this certificate has 2 No 1 Yes 2 XNo 1 Yes Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Grandchild Hospital Other: 4 Nursing Home 5 Residence 6 🛚 Other (Special Residence) 2 13 1 1 Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 124 hours after death. e Funeral Director; After th Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of c 29c License number 29d. Date signed (Month, Day, Year) June 11, 2012 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Dr. Rockville, MD 20850 Geoffrey Coleman M.D.

State Registrar 32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death 2012 Year Physician/ 11% Camilla Ellis June 2:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 608 47th Street Dundalk Baltimore Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months 215-28-9335 Hours **Director** August 12, 1 M 2 X F 80 1931 Maryland Usual Residence of Decede show 10a. State 10h Count at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Md. Baltimore Dundalk 1 Yes 2 No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral 608 47th Street death with 21224 must USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 0 ģ 1 Never Married 2 X Married Yes 2 XNo should be filed within 72 hours after 21215-0036 1 Yes 2 No Specify. White "natural". If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Hygiene. College (1-4 or 5+) the 12 years Secretary Hospital Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o Mental ၉ Patrick Branagan Sophia Zworski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Ellis Husband Health : 608 47th Street, Dundalk, Md. 21224 Page 1 and 2 item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot June 14, 1 🛭 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licens 22 Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death uno Physician/ imu disease or condition resulting in death) Medical Examiner sense dially but one dition a Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No Yes 2 No 1 🔲 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 힏 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 P.O. Division of Vital Records, within 24 hours To the Funeral noletely

State Registrar

mac Oona

31. Date filed (Month, Day, Year) 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

Medical

29a. Certifier

29b. Signatur

(Check

only one

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

801

Certifying Nurse Practifyner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 28, Physician/ ŽÕ12 5:30 PM M Janet C. Filler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Essex Baltimore 340 Stillwater Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Dav. Year 2948 40 Director 15-6 942 Maryland Usual Residence of Decedent Show 10d, Inside City Limits 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Funeral Director 1 🗆 Yes 2 🗷 No BALTIMORE Essex 28a-1 10f. Zip Code 10g, Citizen of What Country? 50 10e. Street and Numbe permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a cany injury or other traumatic event, the Medical Examples once. USÁ Stilwater 2122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) food industry 10 waitress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last) ပ Lillian Florence Miller Harold Kenneth Filler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Stillwater Road Essex, MD Linda Ratcliff/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part . Enter the disease, or complication shock, or heart failure. List only one cau complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final ancer Ph\_sician/ ancreate disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ☐ Pregnant ☐ Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy perform 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 1 Yes completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 2 To the F the

> State Registrar

Date filed (Month, Day,

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certifie

3 🗆

Name and address of person wi

Nagno

811

ted cause of death (Item 23a) (Type

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

une

mo

2012